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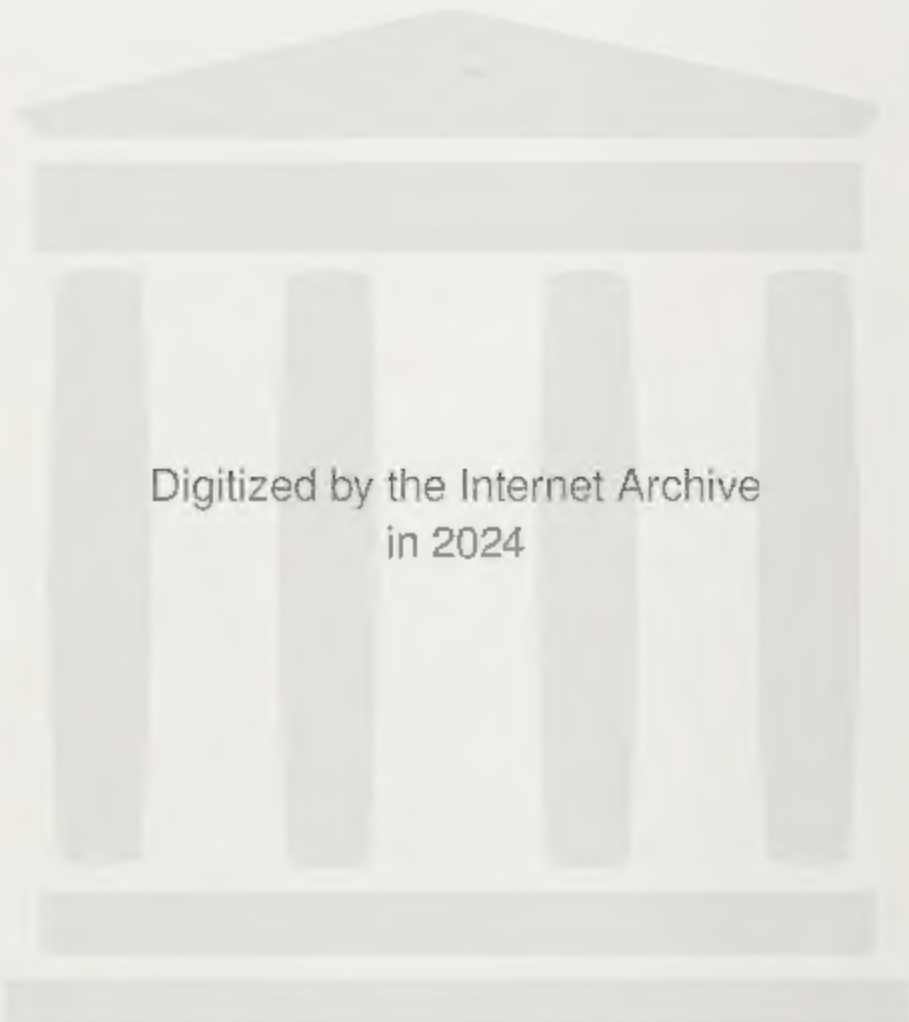
Dr Peter Tarnesby

ABORTION

a Sunday Times guide to abortion within the law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HERMAN PETER TARNESBY, M.D., M.B., B.S., D.P.M., D.Obst R.C.O.G., is a highly-qualified Harley Street specialist who has specialised in gynaecology and psychiatry. He has written on many medical subjects including chapters on "Treatment of so-called frigidity in women" and "Treatment of premature ejaculation" (German Symposium, 1955) and Contraceptive Technique (*Lancet*, 1953).

This is not a guide to immorality; nor is it a recommendation for free love. It is a frank and thorough study of the legal and medical implications of one of the serious social problems of our age—abortion. Dr. Tarnesby, a Harley Street specialist, takes the reader step by step through the problems facing the would-be mother, whether married or unmarried. On what grounds can she receive an abortion? How does she set about it? What are the medical aspects? What are the medical problems? How much will it cost? Dr. Tarnesby answers these and many other questions.

ABORTION EXPLAINED

This guide is dedicated to my three wonderful daughters, Ruthie, Sylvie and Georgia, in the sincere hope that they may read it with interested detachment.

Acknowledgements

My thanks are due to Miss Wendy M. McCullough, S.R.N., S.C.M., for help with the manuscript.

Abortion Explained

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"I will not be the earth to an
unwanted seed," said the woman

—J. G. Howells

Introduction

The Abortion Act has become law. When the Queen gave her Royal Assent to this Bill of Parliament on October 27, 1967, Great Britain became the first country in the Western World to permit abortion legally and relatively freely. No other non-Communist country except Japan allows such wide medical limits.

Yet to pass a permissive law by statute is one thing; to see it implemented fairly is another. Experience has shown, for example, that after Sweden introduced legislation in 1938, sanctioning abortion on a more liberal scale than before – though far less liberal than in Great Britain as from now – the number of back-street abortions did not diminish significantly and there is even some evidence of a recent increase in such illegal operations in that country. How can this be explained? – Mainly by the shortcomings of the law and by ignorance.

The aim of this guide is to explain the former and to rectify the latter. It is not intended to enter into controversy over the rights and wrongs of abortion as such. We have heard enough of this for years, indeed for centuries. The problem has been thrashed out at great length in Parliament ever since Mr. David Steel introduced his courageous private bill in the House of Commons. These debates have been widely reported in the Press and on radio and television. There is no need at this stage to go over all the ground again because a decision has been taken: Parliament has decided and passed the Abortion Act. It took effect on April 27, 1968.

But how will it be implemented? One must try to

answer this question and many other questions arising from it: questions which will be asked by women who find themselves with an unwanted pregnancy and who are desperate to seek advice. Who will give them this advice and who can see it through? Who will give guidance to their husbands, their parents and their boy friends? What happens if a doctor is privately opposed to the new law or if there has been no real contact between a patient and general medical practitioner for some considerable time?

One thing is certain, through this Act in Great Britain, the whole world has passed a turning point in its social history. Since the beginning of mankind, women have been burdened with unwanted pregnancies and the fear associated with these has been a prime source of anxiety, influencing the mental health and social conduct of the entire human race. At first there was no relief from this of any kind, only stern condemnation and punishment resulting frequently in a recourse to illegal operation with much ill health and more anxiety. Only gradually has society changed its opinion. It is more likely that other countries will follow Britain's example. But much will depend on our practical experience here within the next few years. If other countries do follow Britain it will have a most fundamental effect on the world's health and art of living. Even now the law, though confined to the territorial limits of Great Britain is, of course, not restricted to its permanent residents here. The law is the law of the place and anyone coming to that place may have the benefit of it. With increasing ease of travel, the world is becoming a smaller place all the time. There is nothing to prevent a foreign woman coming to this country to have her pregnancy terminated under the Abortion Act, provided two doctors

here agree, even though the law of her own country may not permit such an operation there. We thus have a unique situation in the social equilibrium of our time which presents a great challenge to the doctors and medical facilities of this country. This should be met fairly and adequately.

If answers have been found to some of the questions asked anxiously by those in real need, I will have succeeded in what I set out to do.

H. P. T.

London, W.1.
November 1968

Chapter 1

• THE RISKS • THE MENTAL DANGERS • SUICIDAL TENDENCY • FOETAL ABNORMALITIES

On what grounds?

QUESTION

What does "abortion" mean under the new Act?

ANSWER

It means the deliberate termination of a pregnancy before the growing foetus is capable of independent life.

Does the Act make an abortion easier to get than before?

The decision must be made by two doctors – i.e. medical practitioners registered in Great Britain - and, although they are limited by the grounds for abortion laid down by the Act, these grounds are rather widely phrased. The surgeon who carries out the abortion need not be one of the two doctors who decide. Some surgeons may prefer the decision to be taken by two other independent doctors, but the Act allows the surgeon to participate in the decision.

What are the allowable grounds for termination of pregnancy?

IN CONFIDENCE **Certificate A**

Not to be destroyed within three years of the date of operation

ABORTION ACT 1967

Certificate to be completed before an abortion is performed under Section 1(1) of the Act

I, ...
(Name and qualifications of practitioner in block capitals)

of ....

....
(Full address of practitioner)

and I ....
(Name and qualifications of practitioner in block capitals)

of ....

....
(Full address of practitioner)

hereby certify that we are of the opinion, formed in good faith, that in the case of ....

....
(Full name of pregnant woman in block capitals)

of ....

....
(Usual place of residence of pregnant woman in block capitals)

1. the continuance of the pregnancy would involve risk to the life of the pregnant woman greater than if the pregnancy were terminated;
2. the continuance of the pregnancy would involve risk of injury to the physical or mental health of the pregnant woman greater than if the pregnancy were terminated;
3. the continuance of the pregnancy would involve risk of injury to the physical or mental health of the existing child(ren) of the family of the pregnant woman greater than if the pregnancy were terminated;
4. there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.

This certificate of opinion is given before the commencement of the treatment for the termination of pregnancy to which it refers.

Signed .....

Date.....

Signed..... .....

Date.....

FORM H.S.A. 1.
SCF&C Ltd. 3/68

There are two main groups. The first group applies to the pregnant woman herself and these grounds are that continuance of the pregnancy would involve:

(1) Risk to her life; or

(2) Risk of injury to her physical health; or

(3) Risk of injury to her mental health.

The second group of allowable grounds is that continuation of the pregnancy would involve:

(1) Risk to the life, or physical or mental health of any existing children of her family;

or (2) A substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.

How can doctors determine the grounds and arrive at the right decision?

In determining the question of the continuation of the pregnancy involving risk of injury to the physical or mental health of the woman, account may be taken, in the first place, of the *actual total environment* of the woman and, secondly, *the reasonably foreseeable total environment* of the woman. Clearly in any one case the emphasis might be on either the physical or mental health of the mother, or the risk of the foetus and so the child which would be born, or to existing children. Usually several factors are operative in a specific case. The actual or reasonably foreseeable total environment is most important for no branch of medicine today can deal fairly with the patient in a vacuum; in particular the environment is of great importance in considering the mental health and in the bearing of psychological factors. A knowledge and appreciation of psychological and sociological facts and theories is necessary. But the decisive condition

is that any of the risks involved *must be greater than if the pregnancy were terminated.*

What provisions are there for an emergency when the life of a pregnant woman is in danger and a second doctor is not available?

Only in the case of an emergency may an abortion be carried out by a doctor on his sole decision and he must be able to certify, in good faith, that the operation is immediately necessary to save the life or to prevent grave permanent injury to the health of his patient. A special form has to be signed in such a case.

What are the common risks to the life or to the physical health of a pregnant woman?

Since the degree of risk always depends on the individual patient, the medical diagnosis of the condition from which she suffers is but a very rough guide. Also, since the methods of treatment are improving all the time, the prognosis of the various disorders continues to improve. The following list of conditions, taken from a recent report by a Committee of the British Medical Association on Therapeutic Abortion (published on January 20, 1968), must therefore be judged in that light.

Alimentary Conditions: Acute abdominal conditions requiring surgery (though certainly not in all cases); abdominal thrombosis; ulcerative colitis; relapsing duodenal ulcer; inflammation of the small gut or pancreas gland; chronic coeliac disease; gallbladder infection; diverticulosis; liver disease; hepatitis in its various forms; nutritional diseases; cancer.

Cardiovascular Conditions: Heart failure; rheumatic

IN CONFIDENCE **Certificate B**

Not to be destroyed within three years of the date of operation

ABORTION ACT 1967

Certificate to be completed in relation to abortion performed in emergency under Section 1(4) of the Act

I, ...
(Name and qualifications of practitioner in block capitals)

of .....

.....
(Full address of practitioner)

hereby certify that I *am was of the opinion formed in good faith that it *is was necessary immediately to terminate the pregnancy of

.....
(Full name of pregnant woman in block capitals)

of .....

.....
(Usual place of residence of pregnant woman in block capitals)

ing
pro-
iate
mber)

in order 1. to save the life of the pregnant woman; or
2. to prevent grave permanent injury to the physical or mental health of the pregnant woman.

This certificate of opinion is given:—

ing
pro-
iate
ter)

A. before the commencement of the treatment for the termination of the pregnancy to which it relates; or, if that is not reasonably practicable, then

B. not later than 24 hours after such termination.

Signed .....

Date.....

* Delete as appropriate

FORM H.S.A. 2

heart disease (especially mitral stenosis); congenital heart conditions, high blood pressure, heart disorders associated with thyroid malfunction; coronary disease and angina pectoris.

Respiratory Conditions: Pulmonary tuberculosis; emphysema; bronchiectasis; severe asthma.

Kidney Conditions: Nephritis in various forms; any kidney disorder associated with raised blood pressure.

Neurological Conditions: Multiple sclerosis; severe epilepsy; tumours of the brain or spine; abnormalities of cerebral blood vessels; other marked neurological diseases (myastenia, chorea, paraplegias, ataxias, dystrophies).

Skeletal Conditions: Spinal deformities; fracture or pathology of the pelvis.

Skin Conditions: Severe eczema; lupus; systemic sclerosis, etc.

Glandular Conditions: Severe thyroid disease; suprarenal disorders; some cases of diabetes.

Malignancies: Cancer (particularly of the breast); melanoma; whenever radiation has been given (because of risk of foetal abnormality).

Gynaecological Conditions: Cancer of the cervix or body of the womb or of the ovaries; fibroids when complicated by degenerative changes; after certain previous operations.

Obstetric Conditions: Previous eclampsia or pre-eclampsia; repeated long and difficult labours; multiparity – after five or more pregnancies; excessive vomiting.

Despite this long list, less than 10 per cent. of all abortions are carried out for any risk to the life or physical health. Most therapeutic abortions are due to psychiatric indications.

What are the common risks to the mental health of pregnant women?

These cases represent more than 90 per cent. of all therapeutic abortions and they are on the increase. The list of psychiatric conditions given by the B.M.A. Committee must be seen in the light of the previous answer. There is, of course, a great variation of opinion on the psychiatric indications for abortion and the decision is much more difficult to make than in the case of physical conditions.

Reactive Depression – particularly if severe and with risk of suicide; when the mother is in a "state of hopeless and feckless despair".

Anxiety State – when accompanied by marked depression.

Endogenous Depression – depression not the result of external causes, arising from within.

Obsessional States.

Hysteria – when accompanied by severe depression or other serious mental disturbance.

Schizophrenia.

Mental Subnormality – if marked.

In general what matters of course is the *mental capacity of the patient to adapt to the problems of motherhood in the particular circumstances in which she finds herself.*

Is it true that pregnant women often threaten but never commit suicide?

This is not true. The B.M.A. Committee states quite clearly: "The view that pregnant women never commit suicide is fallacious and must not be allowed to influence the decision." Suicidal attempts are made by pregnant women only too frequently, although they

are often "unsuccessful" – a curious way of expressing that a life was not lost. Sometimes the attempt might have started in a half-hearted way, but ends "accidentally" in tragedy.

And the following case actually occurred after the passing of the Abortion Act. It is quoted from the *Sun* of October 29, 1967.

"Shortly after being told by a doctor that she was pregnant, Chinese-born Mrs. Katherine Szeto, of Stockwell, London, jumped from London Bridge and was drowned. The doctor was mistaken and 31-year-old Mrs Szeto, mother of a two-year-old son, was not pregnant, a pathologist said at the St. Pancras inquest yesterday. The coroner recorded a verdict that she killed herself after the husband said she was worried when told she was to have another baby."

What conditions may cause serious abnormalities of the foetus?

Certain infections of the mother: Particularly some virus infections The main example is **German Measles** which, if occurring during the first month of the pregnancy, may cause severe abnormality of the foetus in 80 per cent. of cases. In **Influenza** the rate of foetal abnormality is about twice the normal rate if occurring during the first three months of pregnancy, and in **Smallpox** or **Vaccinia** severe damage may result to the foetus.

Drug-taking by the mother: Thalidomide is the classical example and LSD is another, as well as all cytotoxic drugs. In fact many modern drugs have as yet been insufficiently tested for their effects on pregnancy and it is therefore advisable to avoid taking any drugs during pregnancy unless there are really compelling medical reasons. However, the obvious prob-

lem is that women rarely know that they are pregnant until at least one month of the pregnancy has elapsed. Since the amount of drug-taking, both with and without the advice of doctors, is constantly on the increase, this indication has to be considered relatively often. In some, though admittedly rare, instances, *drug-taking by the father* may have to be considered also, particularly if he has been taking cytotoxic drugs.

Radiation exposure of the mother or father, both therapeutic or accidental, if doses were high (more than 30 rads).

Inherited Abnormalities. Genetically-determined conditions are a very highly specialized subject and advice should usually be sought from one of the regional genetic units which have been set up for the purpose. Cases of mental deficiency in the family, epilepsy, certain blood diseases and whenever pregnancy occurs after the birth of an abnormal child come under this group.

It has been said that in very early pregnancy almost half of the embryos are abnormal: the majority of these abort spontaneously. Since a considerable proportion are not naturally expelled therapeutic abortion has to be considered. It will, of course, not suffice if the risk is slight or indeterminable; it must be *substantial* according to past medical experience. On the other hand, if the pregnant woman is aware of the risk, any degree of risk, she may develop a state of anxiety about it which would have to be considered on its own according to its severity, and its effect on her mental health.

How can one judge the risk to the health of existing children brought about by the continuance of the mother's pregnancy?

This is the so-called "social" clause which is a misnomer. It is perhaps the most controversial clause in the Act. In practice it may apply but rarely stands on its own. If a child's health is going to suffer substantially, then the mother's health is likely to suffer in sympathy, provided she has real maternal feelings. Her suffering of health is as "reasonably foreseeable" as that of her existing child in that case and would be considered as such under the clause pertaining to her health.

If the mother is devoid of such feelings, the arrival of another child may cause her existing child to be cared for by someone else without any risk to its health. Or, if she keeps her existing child with her, at least another source of love may be brought into its life by the arrival of a sibling, which may even improve the existing child's mental health.

And in the case of large families where the mother does care but just cannot give sufficient attention to her existing children in face of the arrival of another, the danger to her own health on account of multiparity may well cover her case.

The clause constitutes an ethical conflict since it authorizes abortion for reasons other than to safeguard the health of the patient – the mother – or to prevent the birth of an abnormal human being, as laid down in the Declaration of Geneva signed by all members of the World Medical Association in 1964. The International Code of Medical Ethics states: "Any act or advice which could weaken the physical or mental resistance of a human being may be used only in his (or her) interest", i.e. *not* in the interest of members of her family even if it be her own existing child or children. Once this principle is extended to any member of her family it may open the way to

further extension, perhaps to her own parents, siblings, husband or even other third parties. To this doctors are naturally opposed.

The sole application of this so-called "social" clause would thus be legal and yet unethical, but, in the light of what has been said above, it is difficult to conceive of circumstances when this dilemma would arise.

Chapter 2

• THE UNMARRIED GIRL • CAN A DOCTOR REFUSE? • THE AFTER EFFECTS • WHAT ABOUT RAPE?

Factors and doctors

QUESTION

Does it matter if the pregnant woman is married or not?

ANSWER

No.

In the case of an unmarried girl what are the factors which are considered important when deciding the grounds for termination?

The girl's career, her marriage prospects, her social and religious group. The birth of an illegitimate child may mean that the mother will be in absolute social isolation and condemned in some communities. Very important, of course, is her age and mental maturity. In general what matters is the *capacity to adapt to the problems of illegitimate motherhood.*

In the married woman what are the psychological and social factors which are considered important when deciding the grounds for termination?

These include:

(1) The personality and capability of the mother.
(2) The number of previous pregnancies and their course and outcome.
(3) The mother's emotional state.
(4) The response of the husband, the marital situation generally – and its "playback" on other existing children.
(5) The living conditions.
(6) Prolonged and or serious physical illness (or mental disturbances) in other members of the family.
(7) The fear of a defective or deformed child.

Certain differences exist in different social groups: an *unplanned* child may cause a *professional woman* acute distress because her career is threatened. In the *semi-skilled social group* large families are more common, marriage is often contracted earlier, and long-term planning is not so evident. A lower I.Q. is usual and housing is poorer. On the other hand, illegitimacy is often more acceptable and may have occurred before in the family.

Example 1:

A 25-year-old Catholic doctor became pregnant after getting drunk at a party. Her father was a strict Catholic, and a G.P. in a rural district; her mother was the less dominant figure at home and rather passive and prone to spells of depression. Just before becoming pregnant, the patient had obtained a post in an obstetric unit and, on becoming pregnant, she became very deeply depressed. She had no idea of the whereabouts of the father of the child and felt her career and prospects ruined. She had a "steady" boy friend, with whom she had had a row before the party.

Example II:

A 39-year-old married woman had been married happily for 15 years. She had had four children, aged 12, nine, eight and one year old. She and her husband were determined to limit the size of their family after the birth of the last child as she had contracted toxaemia during the pregnancy and had also been depressed for six weeks after the birth of the last child. Her husband earned £20 a week; they occupied a three-bedroom house, and the eldest child suffered from quite severe asthma and repeated bronchitis.

She was advised not to take the contraceptive pill because she had varicose veins and her mother had died of a coronary thrombosis. An intra-uterine device was fitted but led to backache and vaginal bleeding, and was removed. Sheath contraception was forgotten once by the husband and she became pregnant.

The patient then became very withdrawn, depressed and irritable; she shouted at her children and repulsed the affection of the younger child. She began to row with her husband and refused any sexual advances on his part. She felt she dare not approach her G.P. for a termination to be considered.

Considering these examples, particularly when the question of risk to the woman's mental health is involved, it seems that doctors often disagree. Does much depend on whether the attitude of the doctor is "liberal" or "strict"?

Yes. In fact it frequently happens that a case is decided differently by two doctors. To a considerable extent doctors are influenced by the leading consultants of their local hospitals. Thus, on account of the pioneering attitude and practice of Prof. Sir Dugald

Baird in the University of Aberdeen, the eastern area of Scotland tends to show a greater proportion of liberally-minded doctors. Conversely, because of the restrictive anti-abortion views held by Prof. H. C. McLaren and Dr. Myre Sims, it is difficult to obtain an abortion in the Birmingham area. Thus one can actually draw a map of the U.K. showing the "liberal" and "difficult" areas, e.g. Aberdeen, London – "liberal"; Birmingham, Liverpool, Sheffield – "difficult".

Is a doctor entitled to refuse an abortion and may he decline to be concerned with an abortion problem?

The new Act contains a specific Conscientious Objection Clause. If a doctor (or nurse or any other person) holds conscientious objections on religious or ethical grounds, he need not participate in any abortion or advise in connection with it. But if it is necessary to save the life, or to prevent grave permanent injury to the health of a pregnant woman then a doctor is duty bound to facilitate an abortion, notwithstanding any conscientious objections he might have. The new Act is, in fact, a permissive law, it tells doctors what they *may* do, but it does not order them what to do. The Medical Defence Union can offer further advice.

It is believed that about 25 per cent. of doctors will take advantage of the exemption clause. About 75 per cent. of these will do so on religious grounds (Inquiry by *Daily Express*).

"In a recent judgement the Brooklyn Supreme Court awarded damages to the extent of £43,000 to Mrs. Barbara Stewart because a doctor *failed* to carry out an abortion on her. The facts were that she

contracted German measles in the fifth week of her pregnancy and that her own doctor, knowing that the infection was likely to harm the child she was carrying, referred her to the Long Island College Hospital, New York, with a request for termination of her pregnancy. There was a second supporting opinion but the gynaecologist refused to carry out the operation because he was a Catholic. She subsequently gave birth to a deaf, blind, mentally retarded child." (*Sunday Express*, October 6th, 1968).

Apart from religious or ethical opposition, what other objections are raised against abortion?

Apart from a specific case – where the medical grounds for a termination may be thought to be untenable – abortion may be opposed by:

(1) Those who think the operation is "dangerous", "horrible", "degrading", or "unnatural".

(2) Those who still think it is "illegal". (It is not, of course, under the proper circumstances.)

(3) Those who believe that the *risk* of abortion is greater than the risk of not carrying it out. (Statistics tend to disprove this.)

(4) Those who believe that the *after-effects* (physical and/or mental) are either disastrous, or more disadvantageous than the termination and that the woman would have been happier with the child.

What are the after-effects of an abortion?

If done correctly, physical after-effects are absent. Mental after-effects, to a large extent depend on the circumstances in which the operation is carried out, the support the woman receives afterwards (as well

as the "public" attitude) and the woman's past psychological history. Generalizations cannot be made on the question of whether the woman would have been happier with the child.

Is any weight attached to the future well-being of the unborn child, when a case for termination is to be considered?

Not really. In therapeutic abortion the law demands that what is considered is the health of the mother (or the foetus) in the present or foreseeable circumstances. Little weight is attached to the future well-being of the unborn child. This is not predictable with precision, but certain data could be used:

(1) That illegitimate children may be more prone to neurotic illness and delinquent behaviour.

(2) That illegitimate children when adult may be more likely to have illegitimate children themselves.

(3) That separation of child from mother *can* be one of the probable causes of psychological and social dysfunction in later life – and such separations occur when there are unwanted babies and children.

(4) That mothers do not only *love* babies; ambivalence is normal psychologically and hate is as much a part of life as love. A child conceived casually, or from an unwanted pregnancy, may well be hated and so overtly or covertly ill-treated.

(5) That adolescent delinquents tend to come from larger families, which are associated with physical immaturity of the children, lower intelligence than normal, poor maternal health

and overcrowding – which, again, have psychological and social correlates.

(6) That some women are selfish (or labelled so). In fact there is no valid reason why a woman should not prefer to continue her career – or acquire material comforts – rather than have an unwanted child; it could even be argued that such a woman, in any case, would probably make a "poor" mother.

Is rape a sufficient ground for termination?

There is no express provision in the Abortion Act but genuine cases are likely to qualify on mental grounds.

Chapter 3

• HOW TO SET ABOUT IT • WHO TO CONSULT • THE HUSBAND • THE PUTATIVE FATHER

How and who

QUESTION

How does a woman set about obtaining an abortion?

ANSWER

First she should, if at all possible, consult her own general practitioner with whom she is registered under the N.H.S., because:

(1) He knows her physical and mental history well, he will probably know her family's history and, if she is married, he will probably know the husband and may be aware of stresses within the marriage and of the patient's general domestic situation.

(2) The G.P. is well placed to assess *any change* in the patient's physical or mental health.

(3) The G.P. is in an excellent position to follow up the patient after termination (either for physical treatment or psychological support).

(4) The patient may feel she has the most faith in her family doctor and so will accept his assessment of her case.

It should be remembered, however, that a family

doctor may have little training or interest in assessing psychological factors and if these are of prime importance a psychiatrist's opinion should be sought.

Suppose the woman is not registered with a N.H.S. doctor or does not wish to consult her G.P.?

This is, of course, often the case. She may have moved to a new address without having changed her doctor. Or her G.P. may also be the doctor of her parents or other members of her family and she may be worried that he might tell them. One step she might take is to move temporarily to another address and after 24 hours register with a new N.H.S. doctor of her choice as a temporary patient. Alternatively, she may consult any doctor of her choice privately.

Can the woman see a specialist – a gynaecologist – without first seeing her own G.P.?

Not under the N.H.S. On a private basis, however, some specialists now seem to be prepared to see patients without an introduction by a G.P., though they always prefer to have a letter from him.

Suppose the G.P. turns down the request for abortion and the pregnant woman is not satisfied with his decision. What can she do?

She can ask her G.P. to refer her to a specialist – maybe a psychiatrist – for another opinion. If that opinion is positive a confirmative opinion might subsequently be obtained from yet another doctor and the law would be satisfied.

What if the G.P. refuses to co-operate, perhaps because he is absolutely opposed to the idea of abortion on religious or conscientious grounds?

The woman has the right to be referred for a second opinion. If her doctor refuses to give her this right she can either change her doctor under the usual N.H.S. procedure or consult any other doctor privately.

Does she need the consent of her N.H.S. doctor before she consults another doctor?

No.

Does a married woman require the consent of her husband?

No. While this will always be preferred – especially if he is also the putative father – it is not legally essential if two doctors think the abortion is justified. If the husband actually refuses to agree to an abortion which two doctors think justified it is for them – the doctors – to make the difficult decision whether to terminate the pregnancy in spite of the husband's refusal, depending on the degree of risk to his wife's health (or, in rare instances, to that of existing children). The husband could bring a claim for loss of parenthood in the courts but he is unlikely to succeed if all parties have acted in good faith.

Does the pregnant woman need the agreement of the putative father of the pregnancy before it is terminated?

No.

What about unmarried girls under 21 – do they not need permission from their father or legal guardian?

No. Of course such permission should be obtained whenever possible, particularly when she is living with them. But if the girl has strong reasons for not confiding in her parents the law does not insist on their permission, provided that two doctors agree and she is at least 16 years old.

"The doctor must always obtain the authority of the girl before he seeks the consent of her parents. If the girl has left home with her parents' agreement and set out on an independent course of life, then parental consent would certainly not be necessary."

(Memorandum from Medical Defence Union published on March 23, 1968.)

Is it legally essential for one of the doctors to be a specialist or a consultant?

No. But it is obviously desirable. For instance, it would be dangerous to the woman if the necessary operation were actually carried out by a doctor who does not have the required specialist knowledge. Again, when considering risk to mental health, a doctor with special experience in this field, i.e. a psychiatrist, is obviously the proper man to call in. It is likely that in most cases a consultant will be concerned because doctors will not wish to take the decision without the experienced opinion which only a specialist can supply.

Nevertheless, the Abortion Act does not stipulate that one of the doctors must be a consultant. In fact, this provision was explicitly excluded after long

debate in the House of Lords, in which one speaker made the point that being a consultant did not necessarily indicate a superior degree of morality or social conscience.

Are there enough consultants to cope with the potential work?

According to the Parliamentary Secretary to the Ministry of Housing and Local Government in 1967 there were 521 obstetricians and gynaecologists in the U.K. and the waiting list for an operation on the N.H.S. – in a non-emergency gynaecological case – was six weeks. Therefore, there may well be too few consultants to cope but no one can be sure at this stage how many women will be seeking abortions.

It should be noted that the term specialist implies a doctor with an interest and experience in a particular branch of medicine. A consultant is a senior doctor in a N.H.S. hospital who has experience and higher qualifications in a particular branch of medicine. A specialist need not be a consultant, but most consultants are specialists in their own field.

How can a woman obtain an abortion privately?

She can consult any doctor in private practice (or see a N.H.S. doctor as a private patient). He will then give his opinion on the grounds for termination. She can then see a gynaecologist in private practice and he can give the second opinion. If both doctors agree that the grounds are satisfactory the gynaecologist can perform the termination on a private basis. If the gynaecologist does not wish to give the second opinion – or does not feel sure of the grounds for termination –

he can refer the patient, privately, to another doctor for the "second" opinion.

Alternatively, the woman can see the private gynaecologist for the first opinion and he can then refer her for a second opinion to another doctor. He can refer her to two other (private) doctors for their opinion – if he does not wish to consider the grounds himself.

Again, if two doctors (in private practice) do not agree, the woman can approach a third doctor for his opinion. *There is no legal limit to the number of doctors she can consult* and she does not necessarily have to consult, for "second" opinions, a doctor recommended by the doctor she consulted first.

All that is needed are two doctors in private practice to consider the grounds independently; if they agree, a termination may be performed by one of them – or by a third doctor in private practice.

Chapter 4

• CHOICE OF DOCTOR • PLACE OF OPERATION • FOLLOW-UP CARE • THE PRICE

How many and how much

QUESTION

What guide to the choice of doctor can a woman obtain?

ANSWER

A list of local doctors is kept at all post offices in Great Britain and all public libraries keep the Medical Register and the Medical Directory. The latter gives all the qualifications and past experience of the doctors listed. (Abbreviations for medical qualifications are fully explained at the front of the Directory. For example, doctors with special experience in psychiatry will usually have the qualification D.P.M. – Diploma in Psychological Medicine, and those with special experience in gynaecology and obstetrics will have the qualification – R.C.O.G. – the Royal College of Obstetricians and Gynaecologists.)

Any doctor may be approached directly if he is in private practice (most doctors accept appointments over the telephone or by letter). Many doctors will see a patient in an emergency without a prior appointment. The choice of doctor may be a matter of reputation or recommendation by other doctors or friends of the patient.

What other factors are important in cases where termination is to be considered?

An early and definite appointment is most important. A depressed, anxious, and agitated woman is made more depressed by a long wait. The second opinion should be obtained as quickly as possible after the first and personal privacy is essential.

It is the writer's opinion that the doctor should tell the woman his decision as soon as possible after receiving a full history and weighing up the facts. Vacillation by the doctor or a promise to write when a decision is made only causes the woman more anxiety.

Moreover it makes things more difficult from the surgical point of view. The operation should be performed preferably before the 12th week of pregnancy (see p. 52) The surgeon should try to be definite over the time of the operation for many mothers will have to arrange for other children to be looked after, for instance. Although "shopping around" to find sympathetic doctors is to be deplored, one can hardly blame a woman who is a "borderline" case for doing this if prevarication and procrastination are common.

Where can the operation for termination of pregnancy be carried out?

Only in:

(1) A National Health Service hospital or clinic; or
(2) A nursing home approved for the purpose by the Minister of Health or Secretary of State under the N.H.S. Act. (These are private nursing homes.)

Competent staff and the necessary equipment for the operation (and for pre-operation and post-oper-

ation care) are obviously essential. A sympathetic nursing staff will naturally help the patient, whose pre-operative state and post-operative recovery – as well as her later psychological adjustment – are profoundly affected by the attitude of those who attend her.

What about follow-up attention?

Under the N.H.S. a social worker's help and psychiatric after-care (if necessary) can be provided and adequate contact and liaison with the patient's G.P. be sought. The "family" can be followed up (in marital cases) and home visiting provided for. Adequate records would be available for a "second-time" case and for research.

Can an abortion be performed free under the National Health Service?

Yes. But in practice only a relatively small percentage of cases are likely to be dealt with under the N.H.S. It is estimated that of the 150,000 abortions to be considered each year, at least 100,000 are likely to qualify legally for abortion. A possible influx of women coming to Britain specifically for abortions (there have already been enquiries from the U.S.A., Canada, Germany, France, and other European countries) would probably raise the total number of cases which will qualify for legal abortions to about 120,000 annually.

But the latest annual figures from the Ministry of Health show that only 6,380 legal abortions were carried out by the Health Service in 1966–67. It is inconceivable that this number could be increased to more

than 20,000 within a year or so because the N.H.S. is already heavily overloaded with urgent surgical and gynaecological cases. In 1964 and 1965 the Emergency Bed Service arranged the admission of about 12,000 abortion cases, and of these at least half, and probably three-quarters, were admissions following spontaneous miscarriage.

How is the figure of 120,000 abortion cases per year arrived at?

The number of registered births is about 1,000,000 in England, Wales, and Scotland. The "criminal" abortion rate is generally accepted to be at least 10 per cent. – that is, 100,000. To this figure one must add the women who would not, before the new law, have considered abortion because they thought it was forbidden and because they felt guilty at interfering with their pregnancy but who may now feel legally entitled to have their case medically considered. Their number is largely guesswork but has been estimated at about 50,000. Thus we arrive at 150,000.

From this one has to *subtract* those who may not qualify for legal abortions – about 50,000 – and to *add* the number of foreign women who come to this country and who may qualify – again about 20,000 per year. The figure of 120,000 thus remains (statistically) as a basic, rough estimate.

If the above figures are roughly correct, what is going to happen to the 100,000 with whom the N.H.S. will be unable to cope?

They will have to be dealt with privately – in the private nursing homes licensed for the purpose by the

Minister. At the time of writing (June 1968), 110 nursing homes have applied to the Minister for a licence and 75 licences have been granted. Assuming that each licensed private place has about 10–12 beds, there are perhaps 1,000 beds available for this purpose. To meet the potential demand each private bed would have to cope with about 100 cases per year – approximately three days for each case. Abortions after the 16th week of pregnancy frequently require a bed for more than six days.

What do the first published figures show?

The Registrar-General's return for the June 1968 quarter shows that of a total of 4,412 abortions, 3,076 were on the ground of risk to the physical or mental health of the pregnant woman, and 517 on grounds of risk to the health of existing children. Of 1,999 single women whose pregnancies were terminated, 92 were under 16 years of age (4·6 per cent.); 512 between 16 and 19 (25·5 per cent.); 1,274 between 20 and 34 (63·7 per cent.); 44 between 35 and 44 (2·2 per cent.) and one woman was over 45. In 76 cases the age of the woman was not ascertained.

Three hundred and forty-five abortions were carried out on widowed, divorced or separated women.

In answer to a House of Commons question, Mr. Kenneth Robinson, the Minister of Health, said that 13,042 abortions had been notified in the period April 27 to October 8, 1968; 8,097 of them had been carried out in N.H.S. hospitals – 4,945 privately in licensed clinics.

Translated into yearly rates this would mean about 19,000 abortions in N.H.S. hospitals – close to the estimate given on page 39 – and about 12,000 in

private nursing homes, making a yearly total of some 31,000. This is quite certainly an understatement.

The figures for the first few months after the Act came into force cannot be a reliable guide to the future, since it will take a considerable time for women to realise to what extent they can now get help from it. Even doctors are relatively uninformed as yet and some are slow to realise the implications. It is therefore virtually certain that the total figures will run at considerably higher rates next year and the year after.

Also there is a reluctance on the part of doctors to report all their abortions to the Ministry of Health. Sometimes they are beseeched by their patients not to disclose their names. In general doctors dislike what they consider an infringement of medical secrecy. By not registering abortions they do, of course, break the law and are liable to a fine of £100 in each case and even prosecution, but there is little doubt that the number of semi-legal abortions – a class of abortion which is legal in every respect save for notification – runs into thousands.

At the same time the number of frankly illegal abortions, not usually done by doctors and without fulfilment of the essential conditions of the law, certainly still exceeds the above quoted figures, but may be expected to gradually decrease in proportion.

What are the conclusions arising from the figures?

There is at present a great struggle for the available beds. Only patients with very pressing, clearly evident grounds are likely to get treatment under the National Health Service. As for private nursing home beds, the

laws of supply and demand are likely to make them expensive to obtain for abortions.

What is a private abortion likely to cost?

When the *Daily Express* (November 21, 1967) asked a sample of doctors to estimate the total fees for abortion patients using private hospital beds the answers were: Under £50 – by 2 per cent. of the doctors; £50–£100 – 22 per cent.; £100–£150 – 44 per cent.; over £150 – 32 per cent. In the circumstances which are clearly foreseeable, the middle range of these figures will probably develop into a minimum fee.

Of course these are total fees and include the cost of the nursing home (i.e. use of the operative theatre and stay in the nursing home); the fee of the anaesthetist; laboratory fees; the fee of the doctor considering the grounds for the operation; the actual operative fee and post-operative care. A private survey carried out in the London area revealed fee estimates very close to those received by the *Daily Express*.

NOTIFICATIONS OF ABORTIONS IN ENGLAND AND WALES From 27th APRIL TO 2nd JULY 1968

FROM REGISTRAR GENERAL'S QUARTERLY RETURN (NO. 478)

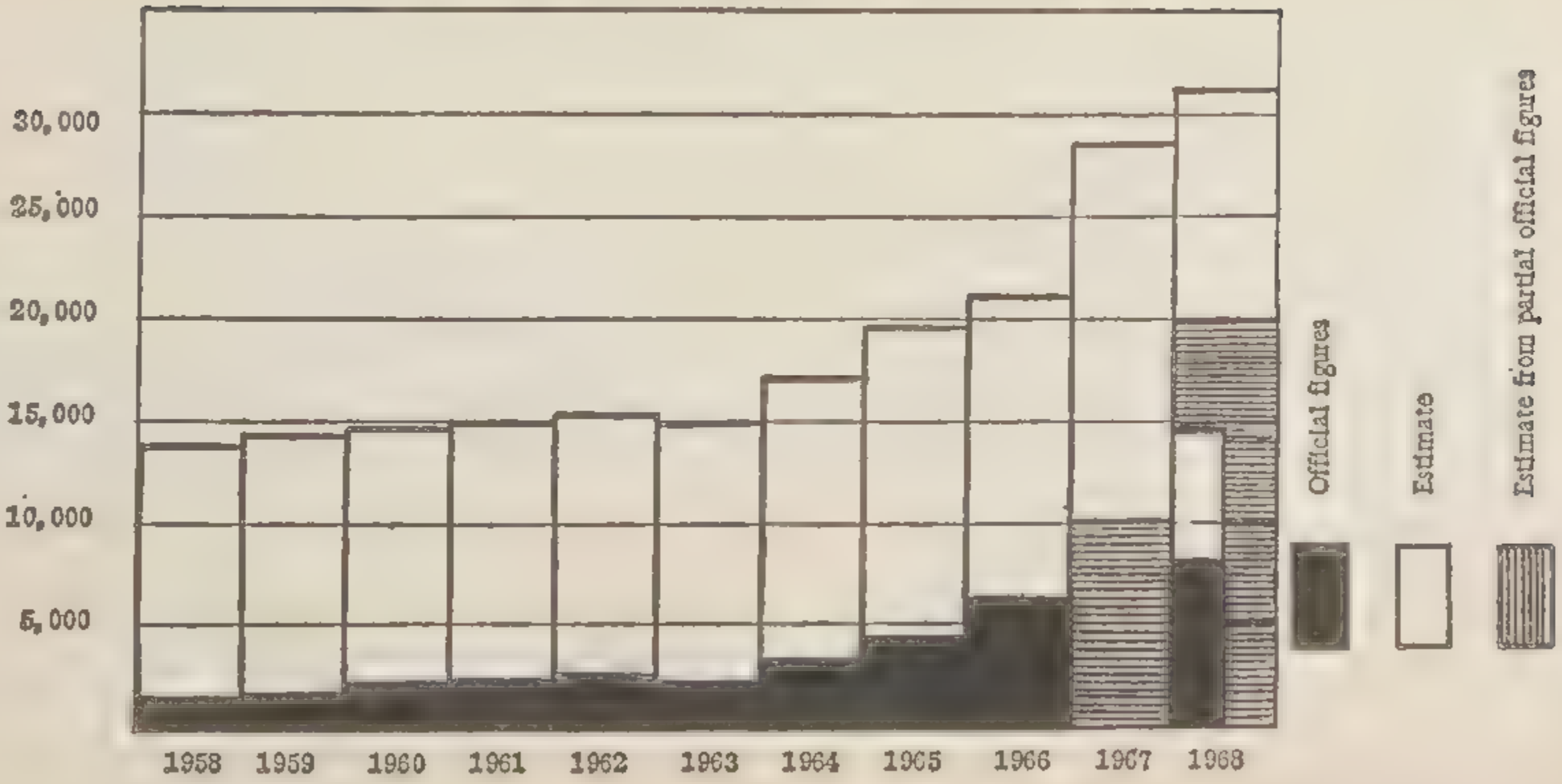
GROUNDS	SINGLE							MARRIED							WIDOWED, DIVORCED AND SEPARATED						
	Under 16	16–19	20–34	35–44	45 & over	Not stated	All Ages	Under 16	16–19	20–34	35–44	45 & Over	Not stated	All Ages	Under 16	16–19	20–34	35–44	45 & Over	Not stated	All Ages
1	1	18	55	3	1	3	79	—	—	76	72	3	6	157	—	1	14	5	—	1	20
2	82	450	1127	39	—	68	1766	—	15	641	402	18	24	1100	—	6	144	50	3	2	205
3	1	3	15	—	—	1	20	—	2	70	34	2	6	114	—	1	26	9	—	2	38
4	3	27	36	—	1	1	68	—	6	184	19	4	3	216	—	—	5	—	—	—	5
5	—	—	—	—	—	—	—	—	—	1	1	—	—	2	—	—	—	—	—	—	—
6	1	1	2	—	—	—	4	—	—	4	5	—	—	9	—	—	—	—	—	—	—
2 with 4	3	6	16	—	—	2	27	—	1	39	14	—	1	55	—	—	4	—	—	—	4
3 with others	2	7	23	2	—	1	35	—	2	254	136	3	12	407	—	—	51	19	—	3	73
TOTAL	92	512	1274	44	1	76	1999	—	26	1269	683	30	52	2060	—	7	244	83	3	8	345

GROUNDS	NOT STATED							ALL WOMEN						
	Under 16	16–19	20–34	35–44	45 & Over	Not stated	All Ages	Under 16	16–19	20–34	35–44	45 & Over	Not stated	All Ages
1	—	—	—	—	—	—	—	—	18	145	80	3	10	256
2	—	—	2	2	—	1	5	82	471	1914	493	21	95	3076
3	—	—	—	—	—	—	—	1	6	111	43	2	9	172
4	—	—	1	—	—	—	1	3	33	226	19	5	4	290
5	—	—	—	—	—	—	—	—	—	1	1	—	—	2
6	—	—	—	—	—	—	—	1	1	6	5	—	—	13
2 with 4	—	—	—	—	—	—	—	3	7	59	14	—	3	86
3 with others	—	—	—	2	—	—	2	2	9	328	159	3	16	517
TOTAL	—	—	3	4	—	1	8	92	545	2790	814	34	137	4412

GROUNDS

1. Risk to life of woman.
2. Risk of injury to physical or mental health of woman.
3. Risk of injury to physical or mental health of existing children.
4. Substantial risk of physical or mental abnormality in unborn child.
5. In emergency as 1 above.
6. In emergency as 2 above.

BRITISH ABORTION STATISTICS 1958-1968



YEAR	Therapeutic Abortions In National Health Service Hospitals	ESTIMATE of Minimum Number of Private Therapeutic Abortions	ESTIMATE of Criminal Abortions	DEATHS		
				Spontaneous Abortions	Criminal Abortions	Therapeutic Abortions
1958	1,570	12,000	100,000			
1959	1,880	12,000	100,000			
1960	.2,040	12,000	100,000			
1961	2,280	12,000	100,000		23	
1962	2,830	14,000	100,000	24	29	4
1963	2,580	14,000	100,000 +	24	21	4
1964	3,300	15,000	100,000 +	22	24	4
1965	4,530	15,000	100,000 +	25	21	6
1966	6,380	15,000	100,000 +	19	30	4
1967	Estimated 10,000	17,500	100,000 +		17	
1968	27.4.68 - 30.9.68 8,097	27.4.68 - 30.9.68 4,945	100,000 +		16	2

Chapter 5

• BREAKDOWN OF FEES • CONTRACEPTION • WHEN CAN THE ABORTION BE CARRIED OUT?

Method and timing

QUESTION

How are the fees for a private abortion made up?

ANSWER

These are the *approximate* figures for an abortion carried out privately. In London and some other cities the prices will probably be considerably higher.)

	Minimum	*Maximum*
Examination fees and written opinion re. legal grounds	£5	£10
Second opinion	5	10
Initial examination by surgeon	5	10
Laboratory fees (Blood tests, blood groupings, bacteriology, cytology, etc.)	2	10
Operation theatre fee	10	30
Specialist anaesthetist	10	30
Operation fee	40	150
Assistant's fee	5	30
Nursing home stay (1 3 days)	10	30
Additional days, if required, per day	5	12

An abortion after 10 weeks of pregnancy, requiring

two days in the nursing home, will thus cost £92 (5 + 5 + 5 + 2 + 10 + 10 + 40 + 5 + 10). This is a bare minimum in an inexpensive nursing home and the cost would probably be twice as high in a top-class nursing home with maximum comforts and with surgeons of repute.

An abortion by hysterotomy (see page 66) after say 20 weeks of pregnancy, requiring eight days' nursing home care, may cost £165 (5 + 5 + 5 + 5 + 30 + 25 + 50 + 5 + 10 + 25) at a minimum, and £370 (10 + 10 + 10 + 10 + 30 + 30 + 150 + 30 + 30 + 60) at a maximum.

These figures are, of course, very approximate and they can vary more widely than indicated. For instance, it may be necessary as a precaution to make full preparations for a hysterotomy, even though the lesser operation of "D & C" (see page 55) can still be carried out. This means more theatre staff, more instruments, more assistants, more laboratory tests which have to be paid for even if not used.

Can a woman reduce the fees by not staying in a nursing home at all?

No. Perhaps the best thing the new Act has done is to prohibit the carrying out of the operation anywhere but in a licensed place, which means a properly equipped operating theatre of a hospital or nursing home. Some doctors have operated in their surgeries and in private homes (not nursing homes) but this is, of course, considerably less safe for the patient and has now become illegal. A patient should not reduce the number of days at the nursing home for the sake of a small saving that would be medically inadvisable.

For this reason, the minimum charge for staying there is sometimes fixed (£10-£30) irrespective of whether the patient stops one, two or three nights.

Can one reclaim the cost of an abortion from a private medical insurance scheme?

Yes, sometimes. Since the operation is only carried out as a result of medical recommendation, it may be covered by such schemes. For instance, the British United Provident Association (B.U.P.A.) have definitely announced that they will pay for private abortions under their schemes. The Private Patients' Plan (P.P.P.) will do likewise – in most cases. But some schemes carry definite exclusions in claims for all conditions associated with childbirth and this may exclude abortions.

Will improved contraception not reduce the number of abortions?

Only very gradually. There are four phases in the development of population control (Audolsek):

(1) Much illegal abortion
Little legal abortion
No contraceptive service
(2) Increasing legal abortion
Decreasing illegal abortion
Contraceptive service
(3) More legal than illegal abortion
Contraceptive service has reduced total number of both kinds of abortion
(4) Contraception widely accepted
Legal abortion established and decreasing
Illegal abortion practically extinct

We are now at Phase 2 moving towards Phase 3. Also:

(a) For the very poor and unintelligent information about birth control methods may not be easily accessible.
(b) Birth control methods sometimes fail.
(c) For some a wish to become pregnant may be consciously or unconsciously dominant at one period of time, with only a later realization of the consequences of the wish (and its concomitant behaviour).

Has improved contraception reduced the number of illegitimate births?

No. In the U.S.A., for instance, where contraception advice has been available for longer than in other countries the illegitimate birth rate was 7·1 per 1,000 25 years ago and has *increased* to 23·4 per 1,000 today. Only about 10,000 legal abortions are performed in the U.S. per year – the number of deaths from illegal ones is about 1,000 a year.

In Britain of every 6 babies born, one is conceived before marriage (138,000 in 1966).

What is the earliest time after conception that an abortion can be carried out?

In theory there are no limits; in practice the earliest limit is the sixth week of pregnancy, counting from the first day of the last menstrual period. Thus an "eight-week" pregnancy is probably only six weeks old because conception may have taken place 13 days after the first day of the last period. But since the exact day of conception is frequently not known,

whereas the days of the last menstrual flow are usually noted or remembered by most women, this convention of reckoning is generally adopted by doctors.

When a woman has "missed" a period she may be suspicious of pregnancy but if she does not wish to have a baby, she still hopes the period may just be delayed. There are, of course, a number of possible causes for such a delay, such as a slight cold or other infection; change of climate or travel to different environment; emotional tension, or just being "irregular". Only after the period has remained absent for a week or so does she tend to worry more seriously.

Sometimes she will arrange for a urine pregnancy test to be carried out, either through her doctor or through an independent laboratory (some advertise in the press: the cost is about £2). But these tests only become reliable after the 12th day of the calculated "missed" period. If the result is positive she may then seek medical advice, and if in urgent need the operation could be done as early as the sixth week of pregnancy, in practice hardly ever before.

What is the latest time after conception that an abortion can be carried out?

The latest limit in most cases is about 22 weeks. But this last stage should be avoided if at all possible. About the 18th 20th week, the mother experiences "quickening", i.e. the first independent movement of the growing child within her. What has been, to her mind, an anonymous and indefinite little piece of tissue in her body suddenly makes its presence known and this has profound, emotional effects on the mother.

An abortion after quickening is always a grave matter. The after-effects, both as regards guilt feelings

and physical recovery, are more marked and such an operation must be reserved for cases of real urgency.

Premature babies born after only 26 weeks of gestation frequently survive. Some have survived after only 24 weeks and a very small number after 23 weeks. For all these reasons, most doctors will not carry out an abortion after 22 weeks, except in extreme emergencies.

Can an abortion be carried out without any operation?

At the present stage of medical knowledge this is only rarely possible. Research is now in progress to develop an "abortion pill" which, when swallowed, will produce a safe miscarriage. The first such pill (ORF–3858) was developed in 1966 by John McLean Morris and Gertrude Von Wagener of Yale University who used it successfully on rabbits and rhesus monkeys. (Report to American Fertility Soc.)

The first pill for use on human subjects – known as F-6103 – is being developed in Sweden. It has already been tested on 50 women. A number of British research workers are trying to get samples to carry out tests. It acts by stimulating a woman's natural inclination to menstruate even after an egg has formed in the womb. It concentrates in the corpus luteum, the gland that produces progesterones, the chemical responsible for maintaining pregnancy. The 50 women in Sweden had been granted legal abortions and the pill produced "excellent" results in 10 per cent. of them.

The pill is a compound derived from a chemical called diphenylephylene. It was discovered by scientists at Uppsala University and is being developed by

the Ferrosan Company of Sweden. Only one dose appears to be required. (*Science Journal*, January 2, 1968.)

A similar pill is at present the subject of research at a London Teaching Hospital.

Will such a pill ever be the complete answer?

Doubtful, because a large proportion of cases in which it works abort incompletely and still require surgical intervention to ensure complete uterine evacuation afterwards.

The F-6103 pill was given to 20 women in Stockholm, with pregnancies of 44–79 days' duration. Only three of these aborted 100 per cent. (i.e. 15 per cent.) and in seven cases there was no demonstrable effect at all (35 per cent.). (May 1968.)

What about "traditional" methods, such as gin, for self-abortion?

There are, of course, several toxic substances which may *sometimes* produce miscarriages, such as quinine, gin, oleum sabinee, anti-folic acid preparations and so on. They all tend to poison both mother and foetus. The latter, being by far the weaker, succumbs earlier but the mother becomes poisoned and damaged too.

An unmarried girl of 21 took about 50 anti-folic acid pills. She lost all her golden blonde hair, three teeth and most of her finger nails, as well as the foetus! Her blood tests showed a dangerous level of anaemia and she required four months in hospital before she recovered her hair and nails (but not, of course, her teeth).

Occasionally, within a few days of the first missed period, it may be possible to bring on the period by combined injections of oestradiol and progesterone as well as neostigmine. The "success" rate is about 1 in 4, but this is only a clinical estimate from which cases of suggested pregnancy which were not in fact pregnant – have not always been excluded by prior urine tests.

Are they not effective then?

Many preparations taken for self-abortion have no effect on the pregnancy. It is quite common for women to take large doses of "tablets" – without any knowledge of their constituents – to "bring on a period". These are usually given by sympathetic friends. They can be obtained easily from other sources (in one survey: 12 out of 15 chemists; 17 out of 22 drug stores and rubber-goods shops; and 2 out of 3 herbalists). Most women just ask for something to bring on periods for themselves – or for friends.

Extravagant claims are made for some preparations by manufacturers – these generally in direct proportion to the cost. In fact the usual ingredients are iron, ergot, purgatives, and aloes or oil of Pennyroyal. They are worthless: since more than 20 per cent. of pregnancies miscarry spontaneously, these preparations will get the credit occasionally.

How is the operation usually performed up to the 13th week?

By "D & C", which stands for Dilatation and Curettage – dilatation of the cervix and scraping of the contents of the womb with a curette. Ignorance of what is going to happen can be very frightening

indeed, particularly for a young woman already emotionally disturbed by unwanted pregnancy and the need for surgery. She is entitled to straightforward answers about details of the operation.

Is the operation painful?

No pain is felt at all during the operation, because an anaesthetic is always used. This can be either a local anaesthetic in conjunction with a tranquillizer administered beforehand, or a full general anaesthetic. After the operation there may be slight backache or abdominal discomfort, but they are usually no more marked than "period pains". Patients often ask, "Please put me out and do not start until I am completely asleep" – thereby showing overt anxiety. For this reason one prefers the use of a general anaesthetic in most cases.

(1) *A premedication injection* 30–50 minutes before the operation, given into the muscle of the thigh or buttock (Omnopon and Scopolamine or Valium). This renders the patient drowsy and non-caring shortly afterwards.

(2) *Intravenous induction anaesthesia*, given into a vein of the forearm (e.g. Thiopentone). All one feels is a slight scratch of the needle and anaesthetic sleep ensues within moments. The patient feels and knows no more of what follows. When she wakes up, all is over, the pregnancy terminated, and she is comfortably back in her bed.

(3) Inhalation anaesthesia given *after the patient is already asleep*, by rubber mask over the mouth

and nose (nitrous oxide and oxygen and Trilene or Halothene).

Does the operation need any preparation by the woman?

She should have no food at all within five hours of the time set for the operation. Nor should she have a heavy meal within 12 hours. She should equip herself with her own box of sanitary towels (*not* internal ones like Tampax), and a sanitary belt. Trimming the pubic hair short with scissors, between the legs, is a decided advantage.

Otherwise she requires only a nightdress, dressing gown, and slippers. She should take out sharp pins from her hair and remove also any jewellery, and she should tell the anaesthetist about any false teeth and allergies to certain drugs (e.g. penicillin, morphine), and inform him of her blood group if possible.

Is shaving of the pubic hair necessary?

For the operation of D & C it is not essential. Some surgeons still prefer it, but many are quite content if the large hair between the legs is trimmed with scissors – not using a razor at all – leaving the pubic hair intact. The powerful cleaning properties of modern surgical fluids make this practice safe enough. It has great psychological advantages in that it avoids the slow re-growth of the hair which can be very irritating and itching. In addition the woman is not reminded daily for many weeks to come of the terminated pregnancy and it obviates detection by anyone who may see her body.

Chapter 6

• VISITORS • BACK TO WORK • POST-OPERATIVE PRECAUTIONS • AND EFFECTS

After the operation

QUESTION

How is the cervix dilated?

ANSWER

(1) The usual method is the passage of graduated dilators (each one being 1 mm. larger in diameter than the previous one), starting at 2 mm. and proceeding to about 12 mm. in cases up to 10 weeks pregnancy, and to 14 mm. at 12 weeks. At 14 weeks, the usual limit for this operation, one may have to use 16–18 mm. Only in exceptional cases is further dilation to 21 or even 26 mm required, a procedure to be avoided on account of risk of tearing the cervix or subsequent incompetence of the cervical musculature.

(2) If dilation beyond 14 mm. is required, some surgeons prefer the prior insertion of a laminaria tent. This is a pencil-like piece of dried-out seaweed which absorbs moisture after insertion and thus swells to several times its diameter when dry. This is a much slower and therefore more gentle dilatation, but it takes 12 or more

hours to work. The laminaria tent has to be inserted the previous day; thus it becomes a "two-stage operation", with further dilatation by metal dilators following on the next day.

(3) Recently a new method has been introduced from Russia. It consists of dilating the cervix by means of a vibrator, activated by an electric motor. It has a blunt, conical end piece, the size of the cone being gradually increased until the desire dilatation is achieved.

Much depends on the shape, size, and consistency of the cervix, and such factors as previous childbirth and past gynaecological procedures will influence the surgeon for the choice of method.

How is the foetus removed from the dilated womb?

The classical method is by "curettage" or gentle scraping of the internal uterine wall with a currette. This instrument consists of a metal loop with either a sharp, blunt or serrated edge, mounted on a thin, long handle. Its proper use requires skill because the surgeon must "feel" around to locate the exact place where the placenta is attached within the womb without missing any part of it and avoiding the perforation of the uterine wall, which can be soft and paper thin in certain places. When the placenta is loosened, the patient may receive an intravenous injection of ergometrine: this aids the natural contraction of the womb and the placenta plus foetus are frequently expelled at once. If not, ovum forceps are used to extract the uterine contents.

A modern development is the Hungarian **suction method**, used in Communist China and in Soviet

countries. Instead of passing a curette, a hollow blunt metal tube is used which has a side aperture near its end and is connected to a suction pump by means of a sterile high pressure tube. The vacuum is recorded by a pressure gauge and can be controlled by withdrawing or angulating the tube slightly within the cervical aperture. The products of conception are evacuated via the tube through the strength of the vacuum.

Is this completely safe?

This method is more gentle to the inner lining of the womb and in experienced hands it is quicker, but it is limited usually to pregnancies up to 12 weeks. A good deal of experience is necessary with this apparatus to avoid leaving behind small fragments of placenta which are sometimes firmly attached, and which can give rise to secondary haemorrhage.

Furthermore, there is a danger of air-embolism if there is insufficient dilatation, no air space may exist between the cervical canal and the outer wall of the suction curette. The whole womb may thus be forced to contract like the rubber balloon of a Higginson's Syringe. Once the vacuum is released on withdrawing the tube a considerable quantity of air may be sucked into the placental sinuses and the womb springs back into its original shape by elasticity.

Fatal accidents have been reported through this mechanism, particularly in Hungary. It must therefore be stressed that the degree of experience required in the vacuum method is by no means less than that for a classical D & C operation. It should not be embarked upon without special training and guidance from surgeons who have used it for some time.

How long does one have to stay in bed after a D & C?

Sometimes only a few hours, but preferably one should remain under medical observation in a hospital or nursing home for at least one night to ensure the early detection of any possible complication.

How soon can one be visited?

Usually within 1–2 hours after the operation. The patient is generally quite lucid and alert by then.

How soon after can one return to work?

If the work is light and sedentary, usually after 1–2 days, otherwise a few days later.

What precautions are necessary after a D & C?

The patient should wear *external sanitary towels* until all loss of blood or discharge has stopped. Until that time she should not sit in a bath – nor allow bath water to enter her. She can, of course, kneel in a bath and wash herself. Nothing should enter her vagina and no sexual intercourse is advisable for about a week after the discharge has completely ceased.

How long does the show of blood go on after the operation?

Sometimes only for a few hours; sometimes for more than two weeks. It depends on the stage of pregnancy at which the operation was performed, the degree of attachment of the placenta and on the skill of the surgeon.

How much blood does one lose?

Often no more than 2 oz. or half a tea cup. Sometimes as much as a pint. In cases of anaemia, iron tablets are advisable if possible before, and definitely after, the operation, until a normal blood haemoglobin level is restored (about 90 per cent. in most women).

What happens to the foetus?

It is cremated together with the placenta and membranes in the hospital incinerator.

Does the foetus feel any pain?

No. It is not yet conscious and is, therefore, even less aware of what happens than its mother who is anaesthetized. Also its nervous system is not yet developed to feel pain.

Does the operation of D & C affect the chance to have a baby afterwards?

Not at all. On the contrary, if done well, it may *increase* fertility somewhat afterwards because the cervical canal is marginally widened allowing for easier fertilization. One must remember that this operation is sometimes specifically advised in women who have not conceived.

Is there any danger of sterility?

One of the misconceptions has always been the "great dangers" of abortion, especially of sterility. These dangers hardly exist and they have been grossly

exaggerated to persuade women into carrying on with their unwanted pregnancies. The facts are:

(1) The clinical results of D & C abortions in young women with early pregnancies are excellent, particularly with regard to fertility.

(2) Apparently sterile women frequently conceive more easily after a so-called "diagnostic" D & C and there is no real medical reason why a similar effect may not result when an early pregnancy is present.

(3) The majority of young D & C abortion cases become pregnant again whether they want to or not. This is borne out by

(a) the case histories of women delivered of healthy babies and

(b) the numbers requesting a second or third abortion.

Exact figures will soon become available from the Ministry of Health, on account of the compulsory notification for statistics of all abortions.

Is it possible later to discover that the operation has been performed by any sign on the woman's body?

After the hair has regrown (if it was ever shaved), no, except to the examination of an experienced doctor inspecting the cervix with the help of a speculum passed up the vagina.

Does the operation widen the entrance of the vagina or affect sexual sensation?

Not if properly done. A slight widening in the case of very young girls (aged 15–18) does sometimes occur, but it never affects capacity for sexual enjoy-

ment. The latter may be increased in the young woman who was previously too "small" to experience coitus without pain. The operation, in itself, does not affect the sexual life (psychologically) of the patient afterwards, does not affect the sensation of the vagina; does not lead to any pain on sexual intercourse afterwards, and does not affect the actual enjoyment of sexual intercourse.

How dangerous is the operation?

It is actually less dangerous than natural childbirth. The statistical death rate from childbirth is about one per 5,000 mothers, but in mothers over the age of 35 (35–39), it is one per 2,500 and in those over the age of 40, it is one per 1,500. The number of deaths due to abortion in the U.K. is about 50 each year. If we take the number of abortions as 100,000 that will give us an overall mortality rate of one in 2,000.

But this is the rate for *illegal* abortions, carried out under clandestine conditions. Also the number of deaths is known (50) but the amount of illegal abortions is but a rough estimate. If these figures are applied to legal, therapeutic abortions under proper conditions, they must be adjusted by more than 50 per cent. and will, therefore, be lower than the death rate from childbirth. In Japan a published analysis of 108,000 *legal* abortions showed eight deaths - one in 13,000, or three times better than our maternal mortality rate In 1964 Czechoslovakia reported no deaths in 140,000 legal abortions (12 in 561,000). Hungary reported two deaths in 358,000.

What are the chances from a morbidity point of view of damage to the woman's health?

Again, they are small. The Japanese analysis showed complications in 3 8 per cent. of cases. Only half of these had to be admitted to hospital and one-third stayed only one day in hospital, i.e. only one-sixth of 3·8 per cent. or 0 65 per cent. had to be admitted for more than a day. Under the best possible conditions, it is to be hoped that results in this country may be better still.

Do women become depressed after abortion due to guilt feelings?

Guilt feelings are surprisingly quickly suppressed and rarely gave rise to serious depression. Mild grief feelings, while not uncommon, tend to last a matter of two or three weeks; very few last as long as six months. Possible exceptions occur in childless women who do not subsequently have children, when there may be a somewhat increased incidence of depression during the menopausal years. But it is not our experience to find serious psychiatric disturbances after abortion more commonly than one might expect in the population generally.

A review of the published literature permits the following conclusions on psychiatric debility for abortion:

No debility	85 per cent.
Temporary self-reproach but little actual debility	10–15 per cent.
Definite psychiatric illness not necessarily connected with the abortion	1–2 per cent.

Much depends on the attitude of the doctors and nurses treating her; the attitude of relatives and friends – and the attitude of the public generally. Some women feel guilty because they *wanted* a termination (and a sympathetic doctor can help here a good deal); others for reasons not connected with the termination itself – but *displaced* on to that, and others because they are almost *expected* to do so.

And if the woman is not married?

In unmarried girls of rigid, over-moralistic parents, the guilt is more often attached to the sexual behaviour which led to the pregnancy – for this was the behaviour that the parents had overtly or covertly condemned in the past and which had been rebelled against by the girl. A doctor can help again in these cases by encouraging the patient to adopt a rational and objective view of her behaviour.

How is a hysterotomy carried out?

This is a major operation, in which the womb is opened by cutting through the abdominal wall. It is used in those cases where the foetus has grown too large to be extracted through the cervix and vagina – in fact, after the 16th week of pregnancy approximately. The uterus is re-sutured with catgut and the abdomen sewn up in layers, leaving, of course, a scar. Healing takes approximately six days and it is usually necessary to stay six to ten days in a hospital or a nursing home.

The "classical" incision runs from the pubic hair margin upward in the midline towards the umbilicus and is about 4–5" long. This provides the best ex-

posure for the surgeon who may therefore prefer it. On the other hand there exists an alternative incision which runs horizontally just below the pubic hair line (Pfannenstiel Incision) and on healing becomes almost invisible, once the hair has regrown over it. However, using this approach, the operation is technically more difficult and is therefore not always suitable. From the cosmetic point of view the latter is of course preferable to any woman.

Are there any disadvantages?

Fertility is reduced through this kind of operation by about one-third (i.e. if nature would have given the woman three children in the future, she will, statistically speaking, have only two; if she might have had but one or two, she may have none). These figures are based on mass statistics and do not necessarily apply to one individual case. There are thus obvious disadvantages to this operation.

What are the advantages?

It is quite safe, because the surgeon can see all the parts he is handling. He can, therefore, control haemorrhage with greater facility. He may, also, take the opportunity to inspect the other neighbouring organs and perhaps even remove the appendix if this is advisable.

What other methods of abortion are used by doctors?

One method consists of injection of an alkaline antiseptic paste into the uterine cavity. The recipe is

derived from Heiser's paste; he was an apothecary in Prussia who developed it in the last century. It was later modified by Leunbach, a well-known Danish gynaecologist, and has been much used in Scandinavia and Russia.

A similar paste is sold in Britain under the name Utus. The method has gone out of favour, since it is unkind to the patient – she has to experience a painful miscarriage several hours after the injection. The pain may be more marked than in a confinement in full term and sometimes a subsequent "D & C" is still necessary on account of incompleteness of the abortion.

Infection and necrosis of the uterine wall has been known and soap embolism may also occur. Several deaths have been reported in the U.S.A. and it is now hardly ever used in Russia where it was a popular method 20–30 years ago. The morbidity rate after its use is about 19 per cent. (Berthelsen & Ostervaand, 1959).

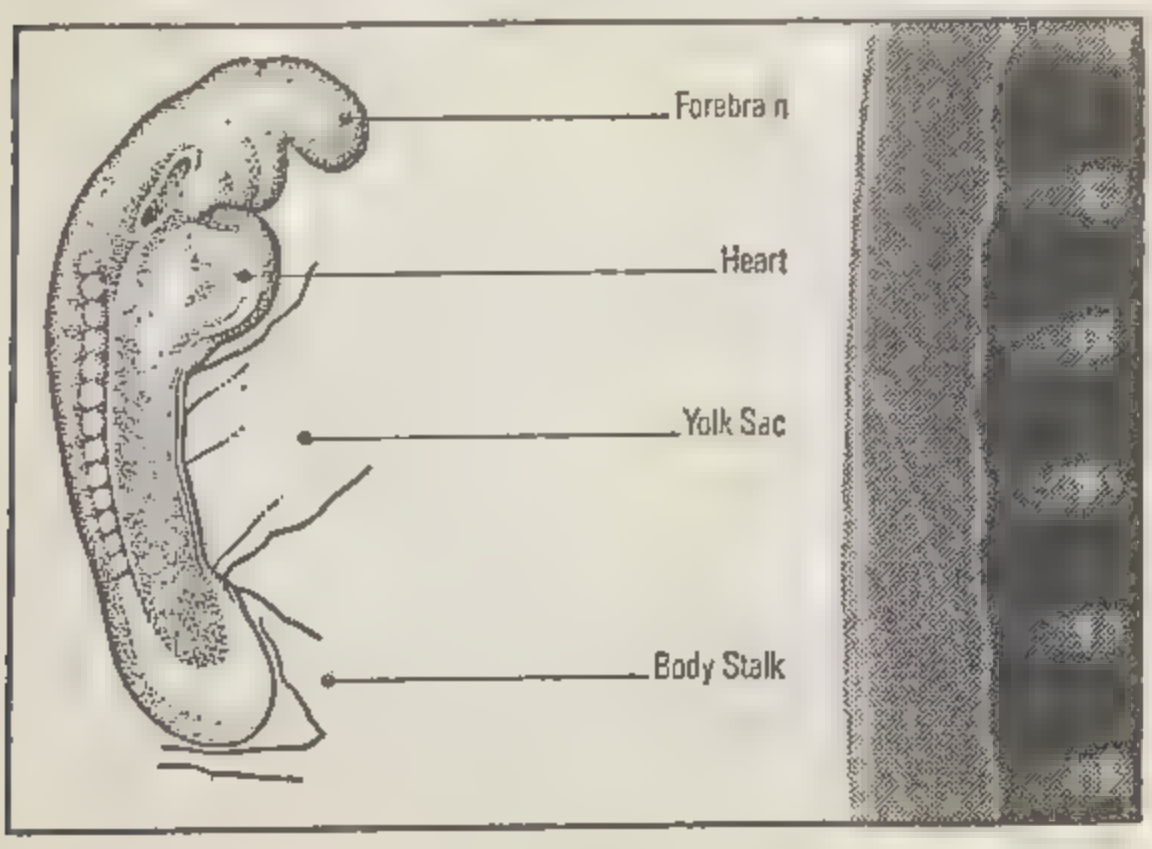
Another method consists of replacing the liquor surrounding the foetus with a hypertonic solution of saline, glucose or urea injected through the abdominal wall. Again, miscarriage ensues with attendant pain and discomfort to the patient. A few fatalities have occurred in which haemorrhages into brain cells were evident in the mother – though it is not yet known why or how. For this reason the method is now hardly used at all in this country. (Cameron & Deyan, 1967; B.M.J. 1, 1010.)

Finally, there is cervical manipulation, a method of massaging the uterus internally. It sometimes works in skilled hands, but is unreliable in its action and produces unnecessary discomfort.

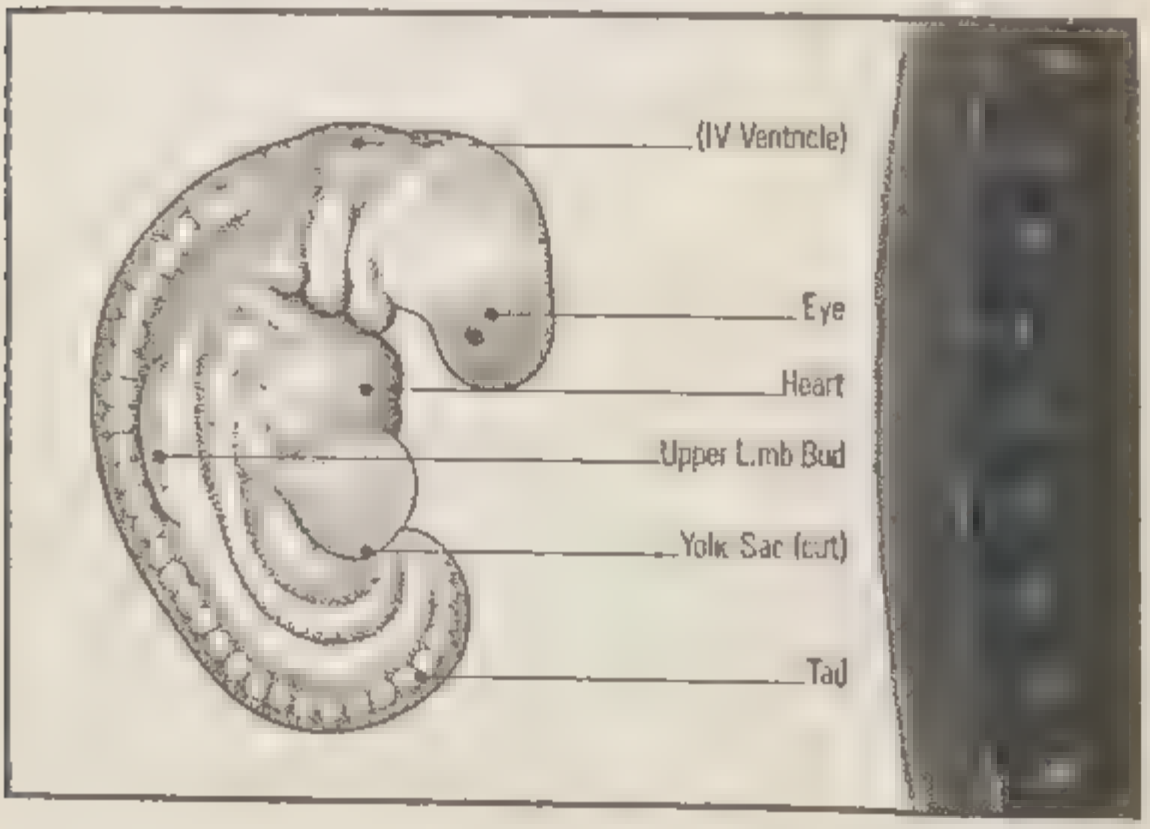
Early pregnancy

The six illustrations show the development of the foetus from the first moment that a girl may think that she is pregnant to the time when some doctors believe that the limit has been reached for a foetus to be extracted vaginally. Abortions can, nevertheless, be safely carried out after 12 weeks (see text).

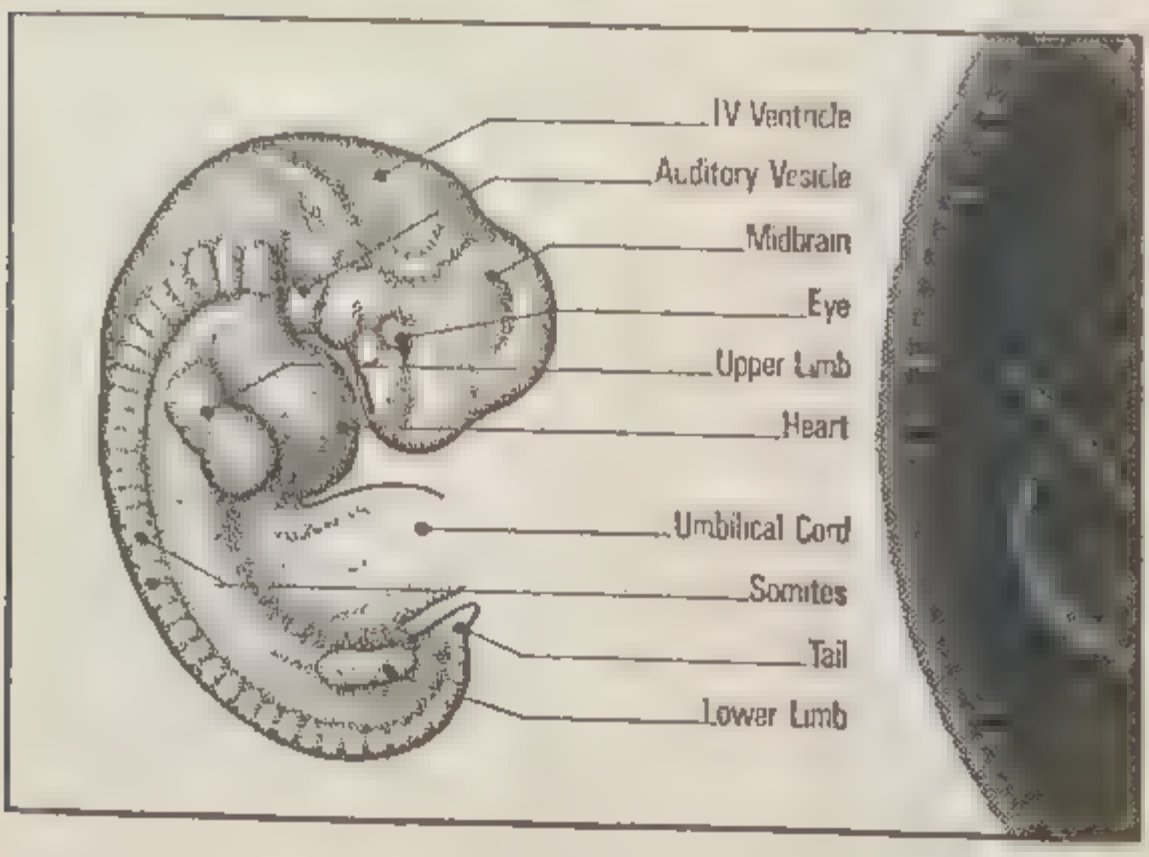
1 *A foetus 23 days after conception compared in size with a halfpenny. At this stage, a girl will have the first suspicions that she may be pregnant.*



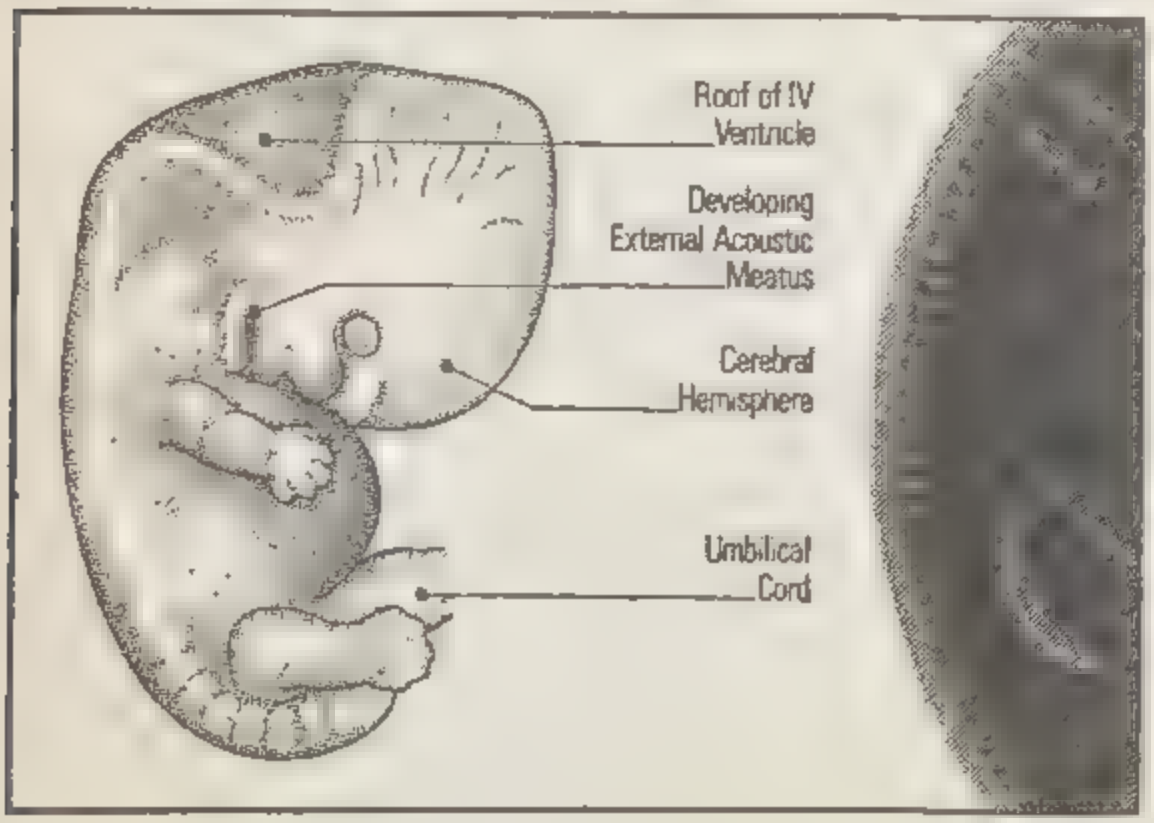
2 *26 days: only three days later, the foetus has grown to 4 mm (against 2.5 in the previous figure) and is showing definite formation of a head and eye.*



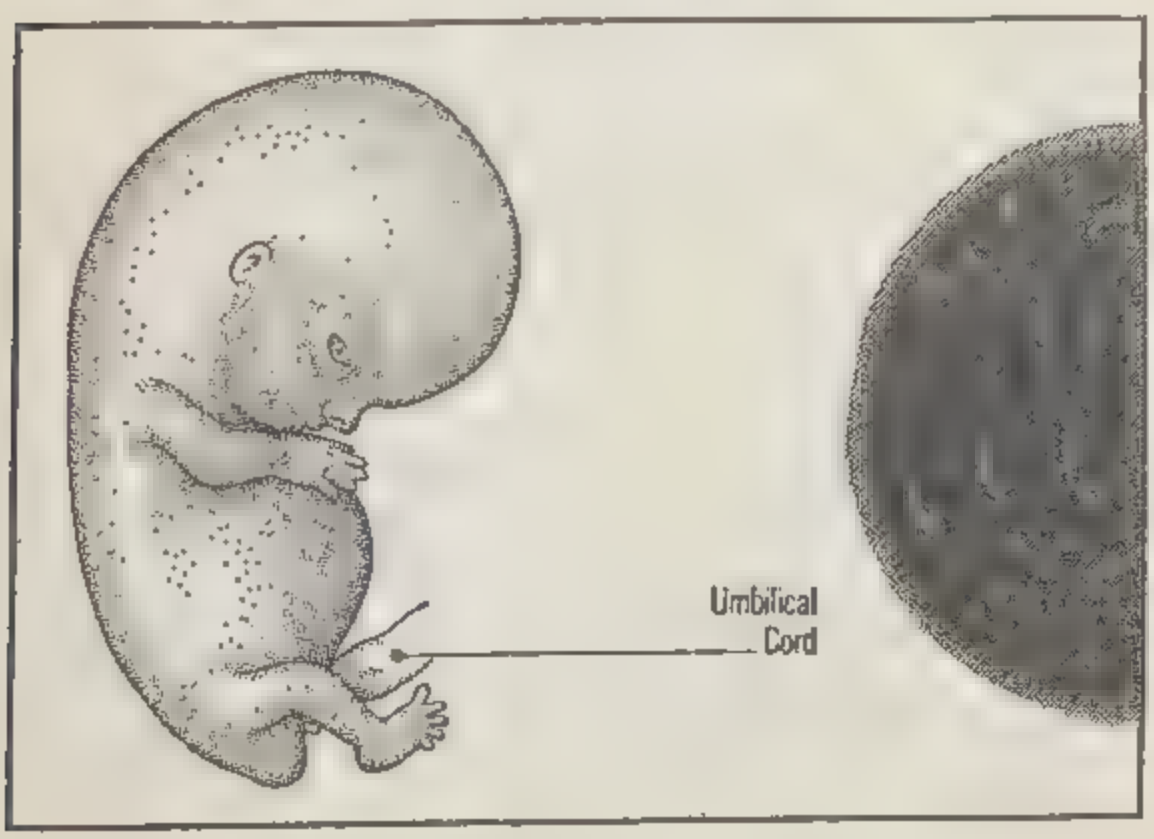
3 *6 weeks: at the time of the second suppressed period. The tiny limb buds are now appearing and the formation of the vertebral column (somites) is more distinct.*



4 *7 weeks: the limbs are now clearly differentiated; hands and feet can be recognised. And the main brain cavity (IV ventricle) is being formed. 15 mm.*



5 *8 weeks: the foetus has a completely human shape. The proportion of head and body are approximately equal and the foetus has doubled in size in a week.*



6 *12 weeks: the time accepted by some doctors as being the limit when a foetus can be extracted vaginally. By this time the third period has been missed*

Chapter 7

• IF DOCTORS REFUSE • GIRLS UNDER 16 • NOTIFICATION • BREACH OF CONFIDENCE?

The law of abortion

QUESTION

If the new Act is but a permissive law authorizing specific exceptions to the basic law of abortion what then is the "Law of Abortion"?

ANSWER

The law relating to abortion is contained in Sections 58 and 59 of the *Offences Against the Person Act 1861*. According to that Act anything done with intent to procure the miscarriage of a woman is a criminal offence.

Section 58: *Use of poison or instruments to cause miscarriage.* "Every woman being with child who, with intent to procure her own miscarriage, shall unlawfully administer to herself any poison or other noxious thing, or shall unlawfully use any instrument or other means whatsoever with the like intent, and whosoever, with intent to procure the miscarriage of any woman whether she be or not with child shall unlawfully administer to her or cause to be taken by her any poison or other noxious thing, or shall unlawfully use any instrument or other means whatsoever with the like intent, shall be guilty of felony."

Section 59: *Supplying or procuring poison or instruments with like intent.*

"Whosoever shall unlawfully supply or procure any poison or other noxious thing, or any instrument or thing whatsoever, knowing that the same is intended to be unlawfully used or employed with intent to procure the miscarriage of any woman, whether she be or not with child, shall be guilty of misdemeanour."

The only exceptions to the basic principle are now laid down in the new Abortion Act of 1967.

Another relevant legislation is the Infant Life (Preservation) Act, 1929.

Section 1: *Infant Life (Preservation) Act, 1929.*

"Subject as hereinafter in this subsection provided, any person, who, with the intent to destroy the life of a child capable of being born alive, by any wilful act causes a child to die before it has an existence independent of its mother, shall be guilty . . . of child destruction . . . Provided that no person shall be found guilty of an offence under this section unless it is proved that the act which caused the death of the child was not done in good faith for the purpose only of preserving the life of the mother . . . For the purposes of this Act, evidence that a woman had at any material time been pregnant for a period of twenty-eight weeks or more shall be prima facie proof that she was at that time pregnant of a child capable of being born alive."

Can an abortion still be illegal today if it is performed by a doctor with the consent of another doctor?

Yes – if any of the detailed requirements of the new Act (e g. form of written opinion, place where opera-

tion performed) are not strictly fulfilled. Again, if the doctors concerned have not acted "in good faith" – if they can be proved, in fact, to have given a wrong opinion for reasons not pertaining to the health or welfare of the pregnant woman or her existing children.

What are the results on the woman if an abortion is refused by the medical profession?

"When abortion is refused the personality disorders and other unfavourable factors present in many cases render the outlook for future adjustment precarious both for the mother and for the child." (Kat & Schopira, B.M.J. February 4, 1967, p. 299.)

Only a few women who are refused an abortion are later glad of it. The majority are not. In a study carried out by Dr. C. M. B. Pare in a teaching hospital constituting 114 patients, 61 had been refused an abortion. Only 38 of these (62 per cent.) continued this pregnancy and had a live baby. A further 23 (38 per cent.) had an abortion in some way or, in three cases, had a premature child and/or stillbirth. Furthermore, of those who continued the pregnancy, a further nine (16 per cent.) had the baby adopted or fostered. In other words, fewer than half the group continued their pregnancy and kept their baby. Workers at University College Hospital certainly have the impression that the majority of women terminated were glad of it. (Dr. Tredgold.)

Two-thirds of the married women with a home accepted the baby and were glad to have it. Single girls or women estranged from their husbands kept their baby only in a quarter of the cases. Two in the 61 cases can be said to have been real disasters. They

both developed quite serious and disabling psychiatric syndromes and required regular psychiatric treatment; one had to go into a mental hospital. There were three other cases who suffered considerably from having the operation refused. Two of the patients died; one went to have an illegal abortion and two months later committed suicide; there had been a history of depression. The second, who previously had mild asthma, developed a sudden attack of severe asthma four months after having been refused the operation and going on to have an illegal one. She died before admission to hospital. In both cases one wonders whether they would not have been much better off if the operation had been granted by a sympathetic doctor in the first place.

What about unmarried girls?

Some workers have found that immature girls persuaded to have the baby remained immature, and that promiscuous, unmarried girls who were refused a termination continued to be promiscuous. It is common for an unmarried woman, who has been refused a termination, to become depressed - especially if she has been kept in suspense about the decision. A large number drift subsequently into prostitution.

Are doctors bound to secrecy in all cases of abortion?

Yes. No doctor is allowed to communicate with the relatives of the patient without her definite consent – whether this be the father, mother, or husband of the patient. This applies also to girls between the ages of 16 and 21.

What is the legal position of a girl under 16?

The doctor must inform her parent even if she herself objects to this. If the parents refuse to give written consent it is still possible for a doctor to carry out a lawful abortion provided the girl herself agrees. Conversely, *an abortion should never be carried out against the express wishes of the girl, even if her parents demand it.*

Do all abortions have to be notified to the Chief Medical Officer of the Ministry of Health?

Yes. The doctor who has performed an abortion is obliged by Law to notify the following particulars to the Chief Medical Officer of Health:

(1) Full name of pregnant woman.
(2) Her usual place of residence.
(3) Her N.H.S. number.
(4) Her maiden name.
(5) Her date of birth.
(6) Her marital status.
(7) Her occupation or that of her husband.
(8) The date of her last menstruation.
(9) The number of her previous pregnancies and
(10) existing children.
(11) Grounds for the abortion and details to date and place.

Does notification of an abortion not constitute a breach of confidence?

The details are notified in confidence from one doctor to another. The Chief Medical Officer of the Ministry of Health, being a doctor himself, is strictly bound not to disclose the confidential information he

has received, except that he must do so in special circumstances. These are detailed in the new Act and include the possibility of disclosure to a police officer authorized by a police superintendent "for the purposes of investigating whether an offense has been committed against the Act or the law relating to abortion" and "for the purposes of criminal proceedings which have begun".

No doubt the Chief Medical Officer will exercise his discretion as to when he *must* disclose details with strict fairness. Nevertheless the medical profession is alarmed and a little worried about this compulsory encroachment on medical secrecy, because it could be a real threat to the doctor-patient relationship which is based on complete confidentiality and also because there must be a danger – one hopes unjustified – that pregnant women will be driven away to seek illegal help with abortions, only because they do not wish to have their names registered as abortion cases in the files of a Ministry.

What then is the purpose of compulsory notification?

To gather accurate statistics for the purpose of future legislation (or measures to be taken by the authorities) and for scientific research.

IN CONFIDENCE

ABORTION ACT 1967

NOTIFICATION TO THE CHIEF MEDICAL OFFICER OF AN ABORTION PERFORMED UNDER SECTION 1 OF THE ACT

I, ...
(Name and qualifications of practitioner in block capitals)

of .....

.....
(Full address of practitioner)

hereby give notice that I terminated the pregnancy of

.....
(Full name of pregnant woman in block capitals)

of .....

.....
(Usual place of residence of pregnant woman in block capitals)

[ ]

The grounds for terminating the pregnancy were certified as —

(Ring appropriate number)

1. the continuance of the pregnancy would have involved risk to the life of the pregnant woman greater than if the pregnancy were terminated;

2. the continuance of the pregnancy would have involved risk of injury to the physical or mental health of the pregnant woman greater than if the pregnancy were terminated;

3. the continuance of the pregnancy would have involved risk of injury to the physical or mental health of the existing child(ren) of the family of the pregnant woman greater than if the pregnancy were terminated;

4. there was a substantial risk that if the child had been born it would have suffered from such physical or mental abnormalities as to be seriously handicapped;

In case of emergency

(Ring appropriate number) The grounds for terminating the pregnancy were:—

5. it was necessary to save the life of the pregnant woman: or

6. it was necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman.

Place of termination

The pregnancy was terminated at:

1. N.H.S. hospital
2. Approved place
3. Other place.

(Ring appropriate number)

☐ (address) .....

.....

☐ on (date) .....

Signature of practitioner who terminated pregnancy

.....

In all non-emergency cases, particulars of the practitioner(s) who joined in giving the certificate required for the purposes of Section 1 should be shown below in the appropriate space(s):—

If the operating practitioner joined in giving certificate, insert at A. particulars of the other certifying practitioner.

A. Name .....

Address .....

.....

Qualifications .....

If the operating practitioner did not join in giving certificate, insert at A. & B. particulars of the two certifying practitioners.

B. Name .....

Address .....

.....

Qualifications .....

	For official use only
Other information relating to the termination	
(Items 1 to 8 to be completed to the best of the knowledge and belief of the operating practitioner):—	
1. N.H.S. Number of woman	.....
2. Maiden name of woman	.....
3. Date of birth of woman	.....
4. Marital status of woman:	.....
1. Single 2. Married 3. Widowed 4. Divorced or separated 5. Not known (Ring appropriate number)	
5. Occupation	.....
NOTE: (a) If woman is married, specify husband occupation (b) If woman is unmarried, specify her own occupation	
6. Date of woman's last menstrual period	.....
7. Previous pregnancies of woman:	
Number of live births	.....
stillbirths	.....
abortions	.....
If applicable, date of last termination of pregnancy under the above-mentioned Act	
.....	.....
8. Number of woman's existing children*	.....
9. Date of admission to place of termination of pregnancy	.....
10. Date of discharge from place of termination of pregnancy	.....
11. Grounds for termination of pregnancy	.....
(a) Medical condition of woman:	
Obstetric disease (specify)	.....
Non-obstetric disease (specify)	.....
(b) Suspected medical condition of foetus (specify)	.....
(c) Non-medical grounds for termination of pregnancy (specify)	.....

* Children mean a woman's natural children and any adopted, foster or step-children, up to the age of 16 years living with her.

12. Type of termination of pregnancy:
    1. Dilation and evacuation
    2. Hysterotomy—abdominal
    3. Hysterotomy—vaginal
    4. Hysterectomy
    5. Vacuum aspiration
    6. Other (specify) .....
    (Ring appropriate number)

13. Was sterilization performed? .....

14. Complications or death prior to notification:
    1. None
    2. Sepsis
    3. Haemorrhage
    4. Death
    5. Other (specify) .....
    (Ring appropriate number)

15. In the case of death, specify cause .....

.....

.....

For office use only

.....

.....

.....

NOTE. This form is to be completed by the operating practitioner and sent in a sealed envelope within seven days of the termination of the pregnancy to the Chief Medical Officer, Ministry of Health, Alexander Fleming House, Elephant and Castle, London, S.E.1.

FORM H.S.A. 3.

SCF&C Ltd. 3/68

Chapter 8

• BACK TO THE EGYPTIANS • THE CASE OF ALECK BOURNE • BEHIND THE IRON CURTAIN

History of abortion

QUESTION

What is the history of abortion in outline?

ANSWER

Egyptian papyrus mentions it without comment; Aristotle advocated it; Plato urged it for every woman over 40; Roman husbands were entitled to *order* it for their wives and slaves; Cicero and Galen condemned indiscriminate abortion; and early Christians called it "infanticide" and condemned it.

A.D. 314: The Church prescribed 10 years' penance for it.

10th Century: Punishable by excommunication from the Church because of the animated soul of the foetus having been murdered.

12th Century: Exemption from excommunication when abortion performed within 80 days of conception in case of female foetus, 40 days for male foetus. (In fact, time of conception can rarely be determined with certainty and the sex of foetus is difficult to ascertain.)

1700–1803: British Law permits abortion before quickening has begun (about 20th week).

1803: Abortion becomes criminal offence in Great Britain from time of conception.

1861: Offences against Persons Act passed by British Parliament.

1869: Pope Pius IX decrees that ensoulment of the foetus commences at conception, thus reverting to position of Church before 12th Century.

1929: Infant Life Preservation Act of Great Britain legalises abortion, but only to save the life of a pregnant woman.

1930: Pope Pius XI declares that abortion is sinful, even to save a mother's life, owing to the equal sanctity of the life of the foetus.

1936: Abortion Law Reform Association formed in Great Britain. (Alice Jenkins, Dr. Joan Malleson, Janet Chance, Stella Browne, Evelyn Fisher, Marie Stopes, Mrs. M S. Garrett.)

1938: Sweden passes relatively liberal Abortion Law.

1939: Lord Birkett's report on Inter-departmental Committee on Abortion with Minority Report by Dorothy Turtle prophesying reform legislation.

1939: British Case Law liberalized by Aleck Bourne Case (Rex versus Bourne 1939 IKB 689) Mr. Bourne, an eminent gynaecologist, had terminated the pregnancy of a 14-year-old girl who had been repeatedly raped by Guardsmen He was found not guilty of unlawfully inducing abortion because the preservation of the girl's life was held to embrace her physical and mental health.

Macnaghten, J., directed the Jury thus: "The burden rests on the Crown to satisfy you beyond reasonable doubt that the defendant did not procure the miscarriage of the girl in good faith for the purpose only of preserving her life. If the Crown fails to satisfy

you of that, the defendant is entitled by the Law of this land to a verdict of acquittal. If, on the other hand, you are satisfied that what the defendant did was not done by him in good faith for the purpose only of preserving the life of the girl, it is your duty to find him guilty . . .

"There are cases, we are told, where it is reasonably certain that a pregnant woman will not be able to deliver the child which is in her womb and survive. In such a case where the doctor anticipates, basing his opinion upon the experience of the profession, that the child cannot be delivered without the death of the mother, it is obvious that as soon as the operation is performed the better. The law does not require the doctor to wait until the unfortunate woman is in peril of immediate death. In such a case he is not only entitled, but it is his duty to perform the operation with a view to saving her life . . . and if the doctor is of the opinion, on reasonable grounds and with adequate knowledge, that the probable consequence of the continuance of the pregnancy will be to make the woman a physical or mental wreck, the jury are quite entitled to take the view that the doctor who, under these circumstances and in that honest belief, operates, is operating for the purpose of preserving the life of the mother."

1946: Sweden broadens grounds to include "medical-social indications"—allowing living conditions of pregnant woman to be considered.

1952: Japan passes Eugenic Protection Law, making abortion possible virtually on demand.

1952: Mr. Joseph Reeves (Lab.) introduces Private Members Bill into Parliament which fails.

1954: Lord Amulree presents unsuccessful Bill.

1955: 1,170,000 legal abortions recorded in Japan in one year.

1955–57: U.S.S.R., Bulgaria, Poland, Hungary, Rumania, Yugoslavia, and Czechoslovakia legalize abortion at the request of the pregnant woman provided this is done before the 12th week of pregnancy. Legal abortions in Czechoslovakia were 7,300 in 1955 but 61,400 in 1958. Hungary has 131 abortions for every 100 live births.

1961: Mr Kenneth Robinson (Lab.), now Minister of Health, unsuccessfully introduces Private Members Bill.

1961–62: Thalidomide disaster producing deformed babies shakes public opinion and reactivates abortion reform.

1964: Home Secretary (Mr. Henry Brooke) declares "time not yet ripe" for Abortion Reform.

1965: Lord Silkin introduces Abortion Bill into House of Lords (three separate attempts); Mrs. Renée Short (Lab.) introduces unsuccessful Bill into Commons.

1966: Family Planning Association holds Abortion conference in London. Silkin's Bill lost.

Rumania reverts to banning abortions.

Mr. Simon Wingfield Digby (Cons.) introduced Bill culminating in (autumn) Mr. David Steel (Lib.) introducing Termination of Pregnancy Bill to Parliament.

1967: (Spring) Colorado the first of the United States to legalize hospital abortions on same grounds as in Sweden.

(Summer) North Carolina follows suit.

(Autumn) California passes similar law but bars abortion for defective children.

October 27: Abortion Act passed in Great Britain (formerly known as the Termination of Pregnancy

Bill of Mr. David Steel); Society for Protection of Unborn Child (anti-abortion reform) founded in England. Lord Barrington is chairman Aleck Bourne a committee member.

1968: (April 27) Abortion Act takes effect.

(July 29) Pope Paul VI decrees encyclical "Humanae Vitae" condemning abortion absolutely "even if for therapeutic reasons". Also forbids all methods of artificial birth control including the contraceptive pill.

(August) Signs of growing revolt against the encyclical; the church becomes divided.

(October) First legal judgment against a doctor for failing to procure abortion.

Chapter 9

• RELATIVELY-LIBERAL SWEDEN • WORLD STATISTICS • COMMON DANGERS • AND COMMON DRUGS

The law abroad

QUESTION

What is the law for abortion in other countries?

ANSWER

In most other countries the law is less liberal than in Britain today.

Sweden enacted a relatively liberal law in 1938, authorizing abortion whenever a pregnancy

(1) threatens grave danger to the woman's health;

(2) results from incest or rape;

(3) is likely to produce a defective child.

However, all applicants are "screened" by a gynaecologist, a psychiatrist and a social worker known as "*kurator*". After this the Royal Board in Stockholm has to consider the decision. Foreign women are rarely accepted.

There were about 6,000 legal abortions a year in Sweden in 1951 for a population of 7·5 million. (By comparison this would be the equivalent of some 45,000 legal abortions in Britain, with a population of more than 60 million.) Only some 700 Swedish abortions are granted under the medical-social clause. About 91 per cent. of women who applied for

abortion were eventually granted one in 1946, but by 1957 this figure had dwindled to 53 per cent. As a result, the number of applicants has dropped off. It was 4,000 in 1961, but has risen again to 5,500 in 1964. The number of illegal abortions in Sweden is still in excess of 10,000 a year.

Delays are so excruciating that 56 per cent. of illegal abortions in the Stockholm area are performed after the 16th week of pregnancy and many are held up until as late as the 24th week. For these reasons many Swedish women flock to

Poland, where abortions can be obtained without much difficulty, as in most

Communist countries, where the present trend is permissive.

France does not allow therapeutic abortion and in consequence has a very high illegal abortion rate roughly equal to the number of live births.

West Germany forbids abortion under paragraph 218 of the penal code except in cases of serious danger to life. According to paragraph 3, a German woman could be punished even for undergoing an abortion in a foreign country in which it is legal.

Denmark has a liberal attitude to abortion—about 20,000 a year (population 4·5 million) according to the Danish Government Commission for Sexual Education.

Switzerland: The law is quite restrictive, but a liberal interpretation of it prevails in the Canton of Geneva, where a **"Commission de Préexpartise"** meets twice weekly to consider applications. Fees for an abortion, if granted, are regulated by law and amount currently to SFr. 625.

U.S.A.: Forty-five of the 50 states allow abortion to save the life of the mother, except Colorado, North

Carolina, and California, which allow abortion under special conditions.

India: Abortion illegal According to the Indian Minister of Health, nearly 200,000 women lose their lives every year through non-medical abortion (*Guardian* November 8, 1967).

Pakistan: Death penalty for abortion still in existence.

Israel: Interpretation of law liberal.

China: Abortion legal.

How many abortions are estimated to occur in the whole world every year?

There are about 120 million live births in the world every year. At least 12 million, but perhaps as many as 30 million, conceptions are estimated to end annually as induced abortions. (U.N. Conference on World Population.) That means that more than 80,000 foetus are expelled and dumped each day behind a bush or in a hole or down the lavatory or in some antiseptic container in some antiseptic hospital. Abortion has been called "the greatest epidemic of all time". (Anthony Smith, *The Body*, 1968.)

How many people die through illegal abortions?

Death from criminal abortion is relatively infrequent, but does occur. In 1938 there were 354 deaths in Great Britain; in 1958 there were 63 deaths; and in 1962 there were 53.

What are the common dangers of illegal abortion?

Drug Dangers: Poisoning by abortifacient drugs may be serious. At least one death has occurred re-

cently in London from quinine poisoning. Lead poisoning used to be common in the past. Anti-folic acid preparations may cause permanent damage.

Structural Damage to Organs: Lacerations from knitting needles with perforation of vagina or uterus and subsequent peritonitis.

Infection: The most dangerous is by haemolytic streptococcus, now mercifully controlled by sulphonemides and antibiotics.

Peritonal Adhesions: Often the result of inter-abdominal infection or damage.

Sterility: Due to endometritis.

Gangrene and **Thrombosis:** From local irritants such as potassium permanganate (a useless abortifacient).

Kidney failure: Due to toxicity, may lead to permanent damage.

Air-embolism: Resulting from soapy water introduced by means of a Higginson syringe or similar instrument. Can prove fatal. The air enters one of the large blood vessels of the placenta and causes an air lock—the vital circulation of the mother, particularly her lungs (pulmonary embolism) and sometimes the brain (cerebral embolism). A quantity of 10cc of air may be sufficient and death may occur in between one minute and 20 minutes. Often due to end of syringe tube being allowed to remain above the level of the fluid.

Fat embolism results from soap particles or strong antiseptics used in syringing the vagina.

Infective embolism from introducing unclean instrument into the mouth of the womb may prove fatal within 12 hours. (Cl. Welchii or tetanus) may lead to septicaemia or bacterial endocarditis or peritonitis.

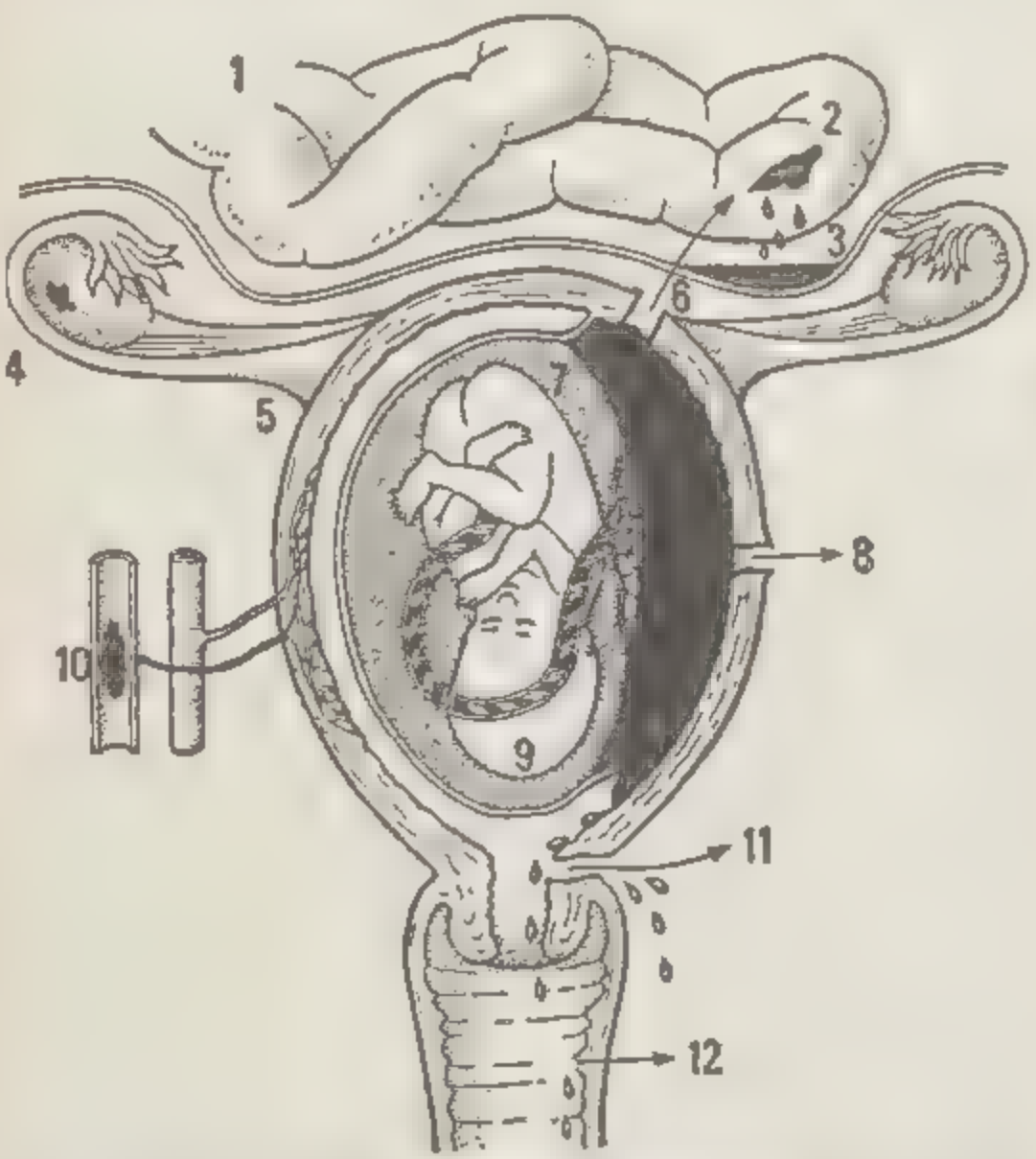
Blood loss due to laceration and incomplete detachment of placental tissue.

Cardiac arrest (vagal inhibition) due to shock. Sometimes occurs due to severe emotional tension while the cervix is dilated. Can be fatal.

Venous thrombosis of the pelvis leading sometimes to blood embolism. Whatever the circumstances, *medical attention must never be delayed.* Speed in obtaining a doctor's help may yet save life or health —and the doctor called is bound by medical secrecy. *He will not inform on the girl,* his duty is to help her. This is an established medical tradition.

Illegal Abortion

The accidents and complications illustrated in the diagram below may not only be the result of illegal abortion; even the most skilled surgeon may incur them, albeit infrequently. In skilled hands the environment is inevitably superior and remedial treatment can be immediate.



12 Laceration of vagina leading to haemorrhage and infection. 11 Laceration of cervix. 10 Clot formation blocking vein (thrombo-phlebitis with or without infection)—or air embolism. 9 Malformation of foetal head, possibly caused by discontinued instrumentation. 8 Perforation through placental site causing internal haemorrhage. 7 Intra-uterine infection. 6 Perforation into peritoneal cavity. 5 Inflammation of the "tubes". 4 Inflammation of the ovaries. 3 Intra-peritoneal haemorrhage, resulting from 2 Punctured intestine (shock), leading to 1 Peritonitis and possible septicaemia.

What are the drugs commonly used in illegal abortion?

(1) Strong purgatives or emetics, producing violent diarrhoea and vomiting, in an attempt to shift the foetus at the same time. Examples are aloes, castor oil and colocynth.
(2) Drugs stimulating the uterus to contract, e g ergot, oxytocin, quinine, oestrogen.
(3) Herbal oils producing pelvic congestion e g. essential oils of bergamot, juniper (contained in gin), rue, savin and tansy, also brook, saffron, colocynth, laburnum, nutmeg and pennyroyal. In Ceylon girls boil a poisonous yam in cow urine or liquid dung and drink the concoction for seven days.
(4) Drugs usually applied to vagina such as mercury salts, copper sulphate, lead preparation (diachylon), potassium permanganate.
(5) Specific drugs such as anti-folic acid preparations depriving the foetus of essential vitamin supply.

All the above-mentioned drugs may produce abortion but only if taken in near-fatal doses. It is a question of poisoning; the foetus may perish first, being much weaker, but the mother always perishes a little and sometimes altogether.

What are the instruments commonly used in illegal abortions?

There is great variety, ranging from hat pins, the traditional knitting needle or crochet hook to matchsticks, bicycle spokes, nails, pokers, extra long fingernails (!), catheters, fine paint brushes, strips of

slippery elm bark (*ulmus fulva*), and enema syringes. The last two are most commonly used in Britain. The elm bark absorbs moisture, swells to several times its dry diameter and thus dilates the cervix.

What are the substances commonly injected into the womb during illegal abortion?

Hot water, soapy water, lysol, formaldehyde, mustard, turpentine.

What other methods are used in illegal abortions?

Various forms of stress and violence varying from hot baths, skipping, horse riding, jumping from height or falling downstairs. All are more likely to harm the mother while the foetus survives.

Has the new Abortion Act brought us close to abortion on demand?

Very close indeed for two reasons:

(1) Nobody can prevent a woman going from one doctor to another, privately, until she has found one who takes a liberal view of her case. He is likely to refer her to a like-minded colleague and she will have reached her aim. But if her case is not really justifiable on medical grounds she may not find support from any doctor. The system favours the woman who has sufficient money to consult one doctor after another privately.

(2) Whatever Parliament may have intended, the wording of the Act allows for an interpretation

which is tantamount to abortion on demand. This is because all that is necessary is to certify that "the continuance of the pregnancy would involve risk to the life of the pregnant woman greater than if the pregnancy were terminated". As Goodhart has pointed out "Since the almost non-existent risk to the life of a healthy woman in an abortion properly performed early in pregnancy is indeed likely to be less than the present very low, but still not wholly negligible, risk in normal childbirth, it is hard to see how any doctor could justify a refusal to give such a certificate" (B.M.J. May 4, 1968, p. 298).

Does the Act apply to the whole of Great Britain?

Yes, except that it does not apply to Northern Ireland.

Chapter 10

• ABSENCE OF PERIOD • NAUSEA AND VOMITING • ENLARGEMENT OF BREASTS • DIAGNOSIS

The early symptoms

QUESTION

Is amenorrhoea (absence of period) a reliable symptom of early pregnancy?

ANSWER

Not altogether.

Cessation of menstruation is of value only in a woman who has previously been regular with her periods. Also there are the following fallacies:

(i) Amenorrhoea (absence of period) may occur from other causes such as infective illness, anaemia, endocrine glandular disorders, emotional stress or change of climate.

(ii) Pregnancy may occur without previous recent menstruation (a) in a very young girl, (b) during lactation of the breasts resulting from previous pregnancy, (c) after a recent "D & C" operation, and (d) after the menopause.

(iii) Menstruation may continue after conception. It is not at all rare for a woman to have one or two periods after she is pregnant but usually the amount of blood lost is small and the character of the flow is abnormal. In rare cases

menstruation has been known to occur for three or even four months after conception and the literature reports isolated instances of persisting periods throughout the full nine months of pregnancy.

What are the other subjective symptoms of early pregnancy?

They are:

(1) Nausea and vomiting frequently in the early morning, but also at any time. It usually begins after the fourth week. The nausea occurs in about one-third of all pregnant women, it is completely absent in another one-third and occurs but occasionally in the remainder. Primiparae (women who have never conceived before) tend to suffer from it more severely. Nervous women are more inclined to it than placid types. Vomiting usually ceases after the 20th week of pregnancy. The symptom is not reliable, because there may be other causes for the sickness, i.e. gastric or duodenal ulcer, appendicitis, gall bladder disease and so on.

(2) Increase in salivation, sometimes accompanied by bleeding gums or loosening of the teeth.

(3) Irritability of the bladder leading to *frequency*. This tends to be marked in the second and third month, but usually lessens afterwards.

What are the objective signs of early pregnancy?

(1) *Enlargement* of the *breasts* may occur as early as the fourth week, often preceded by tingling or burning sensations in them. The enlargement

progresses from the periphery to the centre. *Stretch marks* in the skin of the breasts may appear and *blue veins* become prominent near the nipple. The nipple itself *darkens* and becomes more sensitive and the pigmented area around it becomes puffy, almost as if there were air under the skin and little blisters may form there (tubercles of Montgomery). Sometimes a few drops of fluid (colostrum) may be expressed from the nipple as early as the 12th week, or even before. A secondary pigmented area may form on the periphery of the primary areola, which is of lighter shade. All these changes are more pronounced and reliable in primiparae.

(2) Bluish discolouration of the vagina. This is of an opaque tint with a tendency to violet, appearing between the 8th and 12th week, but it may develop later. It is due to congestion of the veins and may therefore have other causes than pregnancy.

(3) Raised temperature on waking. If this is 99°F. (37·2°C.) or more on 14 successive days it is highly suggestive of pregnancy, provided there are no other causes for fever such as infective illness.

(4) Increase in pigmentation – darkening – of the abdominal midline from the navel downwards (*Linea Nigra*).

(5) The lower abdomen tends to become *flatter*, almost concave, in very early pregnancy when the woman lies on her back. As the French say, *"Ventre flat en enfant il y a."*

(6) Signs discoverable by internal vaginal examination become progressively more reliable after the sixth week.

What is the most reliable method of diagnosing an early pregnancy?

By one of two kinds of pregnancy tests:

(1) The laboratory test (e.g. Hogben) consists of examining an early morning specimen of urine (4 oz. in a clean bottle) either biologically by means of injecting it into large female frogs (Xenopus laevis) who will lay eggs within 15 hours if positive or by pregnancy sensitivity agglutination which can give a result within one hour.

These tests are reasonably reliable (93-98 per cent) but only after the 12th day of the first suppressed period – i.e. just short of six weeks of pregnancy counting from the first day of the last period (L.M.P.). The reliability increases as pregnancy progresses, therefore doubtful results may have to be repeated later on. A negative result is less reliable than a positive reaction.

The current laboratory fee for these tests is about £2, many laboratories advertise directly to the public and a letter of introduction from a doctor is not essential.

(2) Clinical pregnancy test consists of administration of hormone tablets (ethisterone, ethinyloestradiol) or injections (oestradiol and progesterone), usually on two successive days. A "period" due to withdrawal bleeding - a kind of hormone shock – occurs three to eight days afterwards if there is no pregnancy. Absence of bleeding after the ninth day is strongly suggestive of positive pregnancy.

Chapter 11

• ORGANISATIONS TO CONSULT • FURTHER REFERENCE AND READING MATERIAL • MEDICAL TEXTBOOKS

Where to find advice

QUESTION

From what oganizations can further information be obtained?

ANSWER

(1) Ministry of Health, Alexander Fleming House, Elephant & Castle, London, S.E.1.

(2) Her Majesty's Stationery Office, 49 High Holborn, London, W.C.1 (for Statutory Instruments).
or P.O. Box 569, S.E.1. Tel. 01.928.6977.

(3) British Medical Association, B.M.A. House, Tavistock Square, W.C.1. Tel. EUS 4499.

(4) Medical Defence Union, Tavistock House South, Tavistock Square, W.C.1. Tel. 01.387.4244 (Legal duties and rights of doctors).

(5) Medical Protection Society, 50 Hallam Street, W.1. Tel. 01.580.9241 (alternative to 4).

(6) Abortion Law Reform Association, 17 Dunstan Road, N.W.11. Secretary: Mrs. Madeleine Simms; President: Professor Glanville Williams.

(7) Family Planning Association, 231 Tottenham Court Road, W.1. Tel. 01 MUS 9135.
(8) Birmingham Pregnancy Advisory Centre (no fixed address as yet). Chairman: Dr. Martin Cole.
(9) Brook Advisory Centre, 55 Dawes Street, S.E 17 (for young, unmarried people).
(10) London Pregnancy Advisory Centre (No fixed address as yet). Secretary: Mr. A. Golding.
(11) National Council for the Unmarried Mother and Her Child, 255 Kentish Town Road, London, N.W.5 (for help in *continuing* pregnancy).
(12) Children's officer of local council (inquire local Town Hall – also for continuing pregnancy).

Where can one look up further references?

(1) Report on Inter-departmental Committee on Abortion (Lord Birkett), 1939.
(2) "Abortion in Britain" – Proceedings of Conference on Abortion, April 1966 (Family Planning Association).
(3) "Abortion" – *Medical World*, Jan. 1966 (*Journal of General Practice*) a symposium.
(4) "Therapeutic and Criminal Abortion": Chapter in Gredwohl *Legal Medicine*, 2nd Edition 1968, pp. 407–423.
(5) "Indication for Termination of Pregnancy." Report by B.M.A. Committee on Therapeutic Abortion. *British Medical Journal*, 1968, Vol. I, 129–194 (Jan. 20).
(6) "How the Abortion Lobby Worked." Keith Hindell & Madeleine Simms, *The Political Quarterly* Vol. 39, No. 3 (July–September 1968).

(7) "A Guide to the Abortion Act, 1967." *Abortion Law Reform Assoc.* Sept. 1968.
(8) The Registrar General's quarterly return for England and Wales (H.M. Stationery Office, October 31, 1968).

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This is not a guide to immorality; nor is it a recommendation for free love. It is a frank and thorough study of the legal and medical implications of one of the serious social problems of our age—abortion. Dr. Tarnesby, a Harley Street specialist, takes the reader step by step through the problems facing the would-be mother, whether married or unmarried. On what grounds can she receive an abortion? How does she set about it? What are the m ical aspects? What are the medical problen How much will it cost? Dr. Tarnesby answ these and many other questions.

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